Maternal and Child Health Services
Title V Block Grant

State Narrative for California

Application for 2011
Annual Report for 2009

Document Generation Date: Saturday, September 18, 2010

Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

The State of California's Assurances and Certifications and Memorandums of Understanding are available on request.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

>Facilitating Comment on the FFY 2011 Title V Report/Application and the 2011-2015 Needs Assessment Report

To generate awareness, stakeholders and partners were informed that public comment will be sought regarding the FFY 2011 Title V Report/Application and the 2011-2015 Needs Assessment Report. These announcements were made during meetings with stakeholder and advisory groups a few weeks prior to the reports were released. Since the full reports were long and extensive and too lengthy for the public, MCAH developed abridged versions of both reports. Sections included in the 58-page draft FFY 2011 Title V Report/Application for public comment were a state overview, including major state initiatives; agency capacity; impact of the state budget cuts on programs; and, data on national and state performance measures and health capacity and status indicators. Included in the 126-page draft 2011-2015 Needs Assessment Report for public comment were, an overview of social determinants of health; data presenting the health status of the MCAH population; health insurance and healthcare utilization, a discussion on the impact of the state budget cuts to MCAH programs and the priority needs that were identified during the needs assessment process. Both reports were posted on the MCAH website (http://www.cdph.ca.gov/programs/mcah/Pages/MCAH-TitleVBlockGrantProgram.aspx)

The Children's Medical Services (CMS) Branch added a link on the CMS website that connected to the MCAH website and the draft Application/Report, making it available to its partners. CMS posted the full version of the Children with Special Health Care Needs (CSCHCN) Needs Assessment report online.

An e-mail was sent to agencies, organizations, and stakeholder groups targeted for comment or input. MCAH also sought comment from potential stakeholders including the Maternal Childe Health Bureau (MCHB)-funded California principal investigators listed on the MCHB website (http://www.mchb.hrsa.gov/RESEARCH/projects.asp) A CMS Information Notice was placed on the CMS Website informing stakeholders, including the California Children's Services (CCS) administrators, local Child Health and Disability Prevention (CHDP) program directors, deputy directors and medical consultants, and CMS Branch staff, about accessing the draft Application/Report.

Stakeholders were given 2 weeks to provide comment either by phone or e-mail. Most comments were submitted when a reminder e-mail was sent out MCAH responded to each person/entity providing comment.

Comments were received from 27 professionals representing local MCAH programs, offices or programs from various state departments, academia, a health maintenance organization, a professional medical association, a parent and family advocacy organization and a health policy organization.. Seventy percent of those who provided comment acknowledged the great amount of effort that was invested in creating the reports and/ or the high quality and thoroughness of the reports posted for public comment. Responses to HRSA comments in last year's review is included in an attachment.

Themes that emerged from the comments received include constructive suggestions to elaborate on certain health issues or programs that address the needs of the MCAH population, barriers and opportunities for program enhancement, as well as technical edits. Input received in response to the draft reports will be considered and will have its greatest impact during MCAH's strategic planning process.

> Facilitating Input on Programs

Public input is a valuable tool to increase program success and improve services. Input from community members and families have been sought through each of the 61 local needs assessments conducted by MCAH local health jurisdictions (LHJs). Activities related to the local needs assessment and capacity assessment is a form of soliciting public input. Most MCAH LHJs reported that they conducted community meetings, forums and focus groups. These provided the community an opportunity to voice concerns relevant to MCAH health and health care services currently available in the state.

All MCAH-funded programs have a program advisory or workgroup that were formally created. Through regular teleconferences and face-to-face meetings scheduled throughout the year, these advisory or work group members provide voice for program users or clients who tap into the services provided by MCAH programs. Recommendations and input from these groups generally serve to reaffirm our current activities and plans as well as introduce some valuable new ideas such as identifying emerging issues and provide useful feedback for program and policy development.

All MCAH programs systematically and conscientiously make every effort to encourage consumers of program services to give voice to their concerns or provide suggestions on how the quality and effectiveness of MCAH Program can be improved. Most of these are conducted through satisfaction surveys. Results of these surveys are routinely reported in annual reports by local program agencies which is submitted to MCAH. MCAH staff invites input on an ongoing basis via phone, e-mails or through listservs. The MCAH webpages provide a mechanism for the public to e-mail inquiries and comments directly to MCAH.

MCAH stakeholders and partners are kept apprised of changes in federal legislation and the impact of these changes on MCHB Title V funding, recommendations and requirements. Updates are provided via conference calls, in-person meetings or program newsletters with all MCAH partners including but not limited to meetings for the Preconception Health Council of California (PHCC), the MCAH Action Committee, the Adolescent Sexual Health Workgroup (ASHWG), the California Perinatal Quality Care Collaborative and California Maternal Quality Care Collaborative Executive Committees and the Regional Perinatal Programs of California (RPPC).

An attachment is included for this section.
An attachment is included in this section.

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

An attachment is included in this section.

C. Needs Assessment Summary

Every five years California conducts a needs assessment of the maternal, child and adolescent population, which includes children with special health care needs (CSHCN). The needs assessment establishes priorities that guide overall program activities, including those supported by the Title V Maternal and Child Health Block Grant. An attachment to this section documents the 2011-2015 Title V Needs Assessment background, methods, findings, and priorities.

The Maternal, Child, and Adolescent Health Program (MCAH) of the California Department of Public Health (CDPH) conducts the assessment of the MCAH population in collaboration with the Children's Medical Services Branch (CMS) of the California Department of Health Care Services (DHCS), which implements the needs assessment for the CSHCN population. Together, MCAH and CMS administer Title V funds for these respective populations.

The 2011-2015 MCAH needs assessment was based on an extensive local needs assessment process that drew upon the expertise of over 2,700 stakeholders statewide. Each of California's 61 local health jurisdictions (LHJs) conducted a comprehensive local needs assessment, which included stakeholder engagement, a standardized health status assessment, capacity assessment, and identification of priority needs. Technical assistance was provided to LHJs by MCAH and the Family Health Outcomes Project (FHOP) at the University of California, San Francisco. MCAH analyzed a comprehensive set of health status indicators describing population strengths and needs for women of reproductive age, pregnant women, infants, children, and adolescents. The state-level capacity assessment included an internal assessment and a web-survey of statewide partner capacity. Together, the rich findings from the local and state-level assessments informed the identification of needs and the development of priority statements.

CMS conducted the CSHCN needs assessment, with assistance from the Family Health Outcomes Project (FHOP) at the University of California, San Francisco. CMS invited 67 stakeholders to participate in 2 all day meetings for the purpose of identifying issues and prioritizing needs for CSHCN. In addition to the two meetings, stakeholders participated in a series of eight webinars as well as subcommittees for key informant interviews, focus groups, surveys, and needs assessment data.

California's 2011-2015 Title V priority needs are as follows:

- Modify the CCS program, with appropriate funding, to cover the whole child.
- Expand the number of qualified providers of all types in the CCS program.
- CCS will work with appropriate partners to define and create and implement standards for Medical Homes for CCS children.
- Improve maternal health by optimizing the health and well-being of girls and women across the life course.
- Promote healthy nutrition and physical activity among MCAH populations throughout the lifespan beginning with exclusive breastfeeding of infants to six months of age.
- Reduce maternal morbidity and mortality and the increasing disparity in maternal health outcomes.
- Reduce infant mortality and address disparities by promoting preconception health and health care and by preventing causes such as birth defects, low birth weight/prematurity, SIDS, and maternal complications in pregnancy.

- Support the physical, socio-emotional, and cognitive development of children, including the prevention of injuries, through the implementation of prevention, early identification and intervention strategies.
- Promote positive youth development strategies to support the physical, mental, sexual and reproductive health of adolescents.
- Link the MCAH population to needed medical, mental, social, dental, and community services to promote equity in access to quality services.

California's Title V priority statements from the 2006-2010 period were:

- Enhance preconception care and work toward eliminating disparities in infant and maternal morbidity and mortality.
- Promote healthy lifestyle practices among MCAH populations and reduce the rate of overweight children and adolescents.
- Promote responsible sexual behavior in order to decrease the rate of teenage pregnancy and sexually transmitted infections.
- Improve mental health and decrease substance abuse among children, adolescents and pregnant or parenting women.
- Coordinate to develop and implement a system of timely referral between mental health, developmental services, social services, special education services and CCS.
- Improve access to medical and dental services, including the reduction of disparities.
- Expand the number of qualified providers participating in the CCS program, e.g., medical specialists, audiologists, occupational and physical therapists, and nutritionists.
- Increase the number of family-centered medical homes for CSHCN and the number/percent of CCS children who have a designated medical home.
- Decrease unintentional and intentional injuries and violence, including family and intimate partner violence.
- Increase breastfeeding initiation and duration.

The California Title V 2011-2015 Needs Assessment is essential in the cycle of continuous improvement of maternal, child and adolescent health. In 2010, MCAH will develop State Performance Measures and the State Outcome Measure. Through collaboration with our partners, MCAH and CMS will identify strategies to achieve performance and outcome targets, and to improve the health of MCAH populations in the priority areas, especially in the newly identified areas. Between 2011 and 2015, actions and strategies will be implemented, processes and outcomes will be monitored, and modifications will be made as necessary to optimize the life course health trajectories for California women, children and adolescents. As part of this effort, the MCAH and CMS will facilitate improvements to California's MCAH system in response to capacity assessment findings.

An attachment is included in this section.

III. State Overview

A. Overview

>Geography

California is the most populous state and, in terms of total land area, the third largest state in the nation. Covering over 156,000 square miles California is home to numerous mountain ranges, valleys and deserts.1 It is bordered by Oregon to the north, Mexico to the south, Nevada and Arizona to the east, and the Pacific Ocean to the west. Depending on how urban and rural areas might be classified, as much as fifteen percent of California could be designated as rural.2

There are 58 counties in the state with a land area ranging from 47 square miles in San Francisco to 20,053 square miles in San Bernardino. Most counties cover an area greater than 1,000 square miles. The regions with the largest land area include Inyo, Kern, and Riverside Counties. Each of these counties covers an area greater than 7,000 square miles. The smallest regions -- those with less than 600 square miles of land area -- include Santa Cruz, San Mateo, San Francisco, and Amador Counties.1

>Population

In 2010, an estimated 39.1 million people resided in California, an increase from 34.1 million in 2000.3 California's population growth is expected to continue over the next 10 years to reach 44.1 million by 2020.3 Currently, in 2010, an estimated 42% of the population is White, 37% Hispanic, 12% Asian, 6% African American, 2% multi-race, 0.6% American Indian, and 0.4% Native Hawaiian/Pacific Islander. Trends in the racial/ethnic composition of California's population through 2020 predict a continuing decline in the White population proportion and an increase in the Hispanic population, which will become the largest racial/ethnic group in California. The proportions of other racial and ethnic groups in California will remain relatively stable through 2020.

California's diversity is shaped by the multitude of racial and ethnic sub-groups across the state. For example, California's Asian population, the largest in the nation, demonstrates substantial diversity. The largest Asian sub-groups in California are Chinese, Filipino and Vietnamese. Within each Asian group is variation in language and culture. While the largest numbers of Asians reside in the large population centers of Southern California in Los Angeles (L.A.), Orange, and San Bernardino counties, counties with the largest percentage of Asian residents are in the San Francisco Bay Area.3

Hispanic groups in California are predominantly Mexican (83%), followed by other Hispanic or Latino groups from Central and South America (15%). Less than 2% are Puerto Rican or Cuban. Due to shifts in immigration patterns, an increasing number of indigenous Mexicans have settled in California.4 While Southern California has the largest numbers of Hispanic residents, at 77%, Imperial County has by far the largest proportion of Hispanic residents in California. In addition, more than 50% of the population in the agricultural counties of Central California is Hispanic. 5

>Age Distribution

California accounts for one in eight births in the U.S. As with the overall population in California, the MCAH population will continue to grow in numbers and diversity over the next 10 years. The population of children 0-18 years of age has increased to 10.6 million in 2010 from 9.8 million in 2000, and is projected to reach 11.5 million by 2020. Similar increases are expected among women of reproductive age (18-44).

Among each of the MCAH populations, the largest racial/ethnic group in 2010 was Hispanic. Over the next 10 years, the proportion of the population that is Hispanic is expected to continue to increase for all population groups. The White population proportion is expected to continue to decline. Other racial/ethnic groups are expected to remain stable.

For instance, in 2010, an estimated 49.4% of the child population 0-18 years of age was Hispanic, followed by White (30.5%), Asian (9.9%), and African American (5.7%). Children identified in multiple race categories were 3.6%. American Indian (0.5%) and Pacific Islanders (0.4%) made up a small proportion of the overall child population. By 2020, over 52% of children are expected to be Hispanic. The number and percent of Asian children will increase, though not as substantially as Hispanic children. The number and proportion of the White and African American children are expected to decline. Other groups are expected to remain stable.

Young children 0-5 years of age are in a particularly sensitive developmental period, and experiences during this time have great influence over subsequent life course health trajectories. The population of children 0-5 years of age has increased from 3 million in 2000 to 3.3 million in 2010, and is projected to reach 3.8 million by 2020. The 2010 racial/ethnic distribution of the young child population was similar to children overall. As with the overall population, proportion of children ages 0-5 who are Hispanic are expected to continue to increase through 2020, while the proportion that is White are expected to continue to decline. Other racial/ethnic groups are projected to remain fairly stable through 2020. 3

In 2010, there were 8.1 million women of reproductive age (ages 15-44) in California. The largest group was Hispanic women (41%), followed by White (37%), Asian (13%) and African American (6%). The percentage of Hispanic women is expected to continue to increase among this age group through 2020 to 47%, and the percentage of White women are expected to decline to 32%. Other groups are expected to remain somewhat stable.

Of particular interest are the youngest women of reproductive age, who demonstrate increased risks and poorer birth outcomes compared to their older counterparts.6,7 In 2010, there were an estimated 1.5 million females ages 15-19 and 875,000 females ages 15-17 in California. Hispanic females were the largest racial/ethnic group among the 15-19 year olds (47%), followed by White (33%), Asian (10%), and African American (7%). Racial/ethnic distribution was similar among females ages 15-17.

> Immigration

California is home to 9.9 million immigrants, the largest number and percentage of foreign born residents in the United States.8 International immigration has accounted for 40% of California's population growth since 2000. Further, since 44.5% of California births are to women born outside the U.S.,9 the well-being of this population has a strong influence on overall MCAH status in California. Most of California's immigrants are from Latin America (56%) or Asia (34%). The leading countries of origin for immigrants are Mexico (4.4 million), the Philippines (750,000) and China (659,000). 9

Immigration status is related to poverty among children in California, which in turn is a strong predictor of health outcomes. Overall, 48% of California's children have immigrant parents: 34% have at least one legal immigrant parent and an estimated 14% have at least one undocumented immigrant parent. Among these children, 24% of children with legal immigrant parents are poor and 38% of children with undocumented immigrant parents are poor. 10

California has the largest number and proportion of undocumented immigrants of any state.11 Many undocumented immigrants in California experience difficulty in meeting basic needs and accessing services, while facing additional health risks related to low wage jobs that lack protections and benefits. In 2008, approximately 2.7 million undocumented immigrants lived in California, an increase from 1.5 million in 1990. 11 In 2004, approximately 41% of California's undocumented immigrants resided in L.A. County. 10

>Languages Spoken

Limited English proficiency (being able to speak English less than ‘very well') poses challenges for educational achievement, employment, and accessing services, and results in lower quality

care for immigrant communities--each of which influences MCAH outcomes. Among California's population over 5 years of age, 14.3 million speak a language other than English at home and 6.7 million have limited English proficiency. 8

California's linguistic diversity requires the MCAH system to develop linguistic competence in multiple languages. Among youth in California's public schools, one in four is an English Language Learner (ELL) who is not proficient in English. These 1.5 million students speak 56 different languages, but over 1.2 million of ELL students are Spanish speakers. Other common languages are Vietnamese, Filipino, Cantonese, and Hmong. ELL students reside in every county in California, and in 14 counties in California's Southern, Central Valley, and San Francisco Bay areas, ELL students make up over 25% of the student population.12

>Education

In California, one in five individuals over the age of 25 has not completed high school and nearly 10% has not completed 9th grade. Further, measures of educational attainment show that while graduation rates have declined only slightly from 69.6% in 2000 to 68.5% in 2008, drop-out rates have risen sharply from 10.8% in 2000 to18.9% in 2008. 13

Educational attainment varies greatly by race/ethnicity and gender. The 2007-08 drop out rate was higher than the state average for African Americans (32.9%), American Indian/Alaska Natives (24.1%), Hispanics (23.8%), and Pacific Islanders (21.3%), and was lower than the state average for Whites (11.7%), Filipinos (8.6%) and Asians (7.9%).14

California's high school graduation rate for African Americans (59.4%) and Hispanics (60.3%) was substantially lower than for Whites (79.7%) and Asians (91.7%). The graduation rate for females (75.8%) is higher than for males (67.3%) overall, and for each racial/ethnic group.15

>Income

According to the most recent census data, over 4.6 million Californians, 13% of the population, have incomes at or below 100 percent of the federal poverty level (FPL). The 100 percent federal poverty level in 2008 was $21, 200 for a family of four. African Americans, Hispanics, and American Indians have the highest rates of poverty in California.16 Among children under age 18 the rate is higher: 16% of the population is in poverty, or approximately 1.6 million children.17 Projections of child poverty rates through 2012 anticipate that child poverty in California will increase as a result of the recession, peaking at 27% in 2010 before declining slightly to 24% in 2012. In L.A. County, home to 25% of California's children, one in three children is projected to be in poverty in 2010. 18

California child poverty varies tremendously by region. Counties with the highest child poverty rates are in the Central Valley, Northern Mountain, or border regions of California: Tulare (31%), Lake (28%), Fresno (28%), Del Norte (28%), and Imperial (27%). Counties with the lowest rates of child poverty (below 10%) are in the San Francisco Bay Area, Wine Country, and the Lake Tahoe/mountain recreational area. 17

Only examining the federal poverty level obscures the struggles faced by many families in California because of the high cost of living in this state. An alternate measure of poverty is the self-sufficiency standard, a measure of the income required to meet basic needs (housing, child care, transportation, health care, food, applicable taxes and tax credits and other miscellaneous expenses) that accounts for family composition and regional differences in the cost of living. While 1.4 million (11.3%) of California households are below the FPL, an additional 1.5 million households in California lack adequate income to meet basic needs. 19, 20

Income insufficiency is highest among households with children. Among households with children, 36% of married couple households, 47% of single father households, and 64% of single mother households have insufficient income to meet basic needs. Households headed by single mothers in some racial/ethnic groups have even higher rates of income insufficiency. Nearly 8 out of 10 Hispanic single mother households and fully 7 out of 10 African American single mother

households experience income insufficiency. The major financial stressors for households with children are housing and child care; many of these families struggle to meet the most basic needs, cannot afford quality child care, and have limited financial resources to address crises. 20

It is also worthwhile to note that rates of poverty and low income are higher during pregnancy than when measured among children. This means that many more infants are born into financial hardship than statistics on children indicate. 21

>Housing
California's high housing costs create a burden for families, resulting in less income available for other resources needed to maintain health.22 Lack of affordable housing also forces families to live in conditions that negatively impact MCAH outcomes: overcrowded or substandard housing or living in close proximity to industrial areas increases exposure to toxins such as mold and lead, as well as increased stress, violence, and respiratory infections.22 It also exposes families to urban desert, i.e., neighborhoods lacking sidewalks, public parks, grocery stores and parks.

In 2010, the fair market rent in California ranged from $672 in Tulare County to $1,760 in San Francisco Bay Area counties.23 Even for working families, the high cost of fair market rent is out of reach. In California, on average, one wage earner working at minimum wage would have to work 120 hours per week, 52 weeks per year in order to afford a two-bedroom apartment at fair market rent.24

The current foreclosure crisis has greatly impacted California home-owner families. In 2008 and 2009 combined, there were over 425,000 residential foreclosures in California.25 Foreclosure can force families into lower quality homes and neighborhoods, lead to great financial and emotional stress, and disrupt social relationships and educational continuity.

Inability to access affordable housing leads to homelessness for some families. More than 292,000 children are homeless each year in California, which is ranked 48th in the percent of child homelessness in the United States, with only Texas and Louisiana having worse rates among children.26 Homelessness in children has been linked to behavioral health problems,22 and negatively impacts educational progress.26

>Public Health System
The California Department of Public Health (CDPH) is the lead state entity in California providing core public health functions and essential services. The Department has five centers to provide detection, treatment, prevention and surveillance of public health and environmental issues. The MCAH Program, the lead entity that manages the Title V Block Grant is housed under the Center for Family Health (CFH). CFH also oversees provision of supplemental food to women, infants and children, family planning services, prenatal and newborn screening and programs directed at addressing teen pregnancy, maternal and child health and genetic disease detection. The other Centers within CDPH include the Center for Chronic Disease Prevention and Health Promotion which provide surveillance, early detection and prevention education related to cancer, cardiovascular diseases, diabetes, tobacco cessation, injury and obesity; the Center for Environmental Health which is responsible for identifying and preventing food borne illnesses and regulates the generation, handling and disposal of medical waste; the Center for Health Care Quality which licenses and inspects healthcare facilities to ensure quality of care, inspects laboratory facilities and licenses personnel; and the Center for Infectious Diseases which provide surveillance, health education, prevention and control of communicable diseases.

To facilitate health planning and coordination and delivery of public health services in the community, California is divided into 61 LHJs, including 58 counties and three incorporated cities. These cities are Berkeley, Long Beach, and Pasadena. In addition to providing the basic framework to protect the health of the community through prevention programs, LHJs provide health care for the uninsured, which may include mental health and substance abuse treatment services. Given the diversity of these LHJs in size, demographics, income and culture,

tremendous diversity also exists in how LHJs organize, fund and administer health programs.

MCAH allocates Title V funds to LHJs to enable them to perform the core public health functions to improve the health of their MCAH populations. All LHJs must have an MCAH Director to oversee the local program. LHJs must also conduct a community needs assessment and identify local priorities every five years. LHJs address one or more local priorities in their annual MCAH Scope of Work. LHJs must also operate a toll-free telephone number and conduct other outreach activities to link the MCAH population to needed care and services with emphasis on children and mothers eligible for Medi-Cal. Other LHJ activities include assessment of health status indicators for the MCAH population, and community health education and promotion programs. Specific MCAH categorical programs administered by LHJs include AFLP, BIH, CPSP, the Sudden Infant Death Syndrome (SIDS) education and support services, and Fetal and Infant Mortality Review (FIMR).

CCS addresses the health service needs of CSHCN in the state. CCS authorizes and pays for specific medical services and equipment provided by CCS --approved specialist for children with special needs. Larger counties operate their own CCS programs and smaller counties share the operation of their programs with the state CCS regional offices in Sacramento, San Francisco and Los Angeles.

Major State Initiatives
The process used by MCAH to prioritize and address current and emerging issues impacting the health of the MCAH population through its major initiatives is multifaceted. This process includes monitoring the MCAH population health status, consultation with our stakeholders, collaboration with local MCAH directors, partnering with programs within CDPH and with staff from other departments such as the California Department of Education (CDE), the California Department of Social Services (DSS), the California Department of Health Care Services (DHCS) and Alcohol and Drug Programs (ADP) and with a variety of public health educators, clinicians and organizations concerned with the well-being of the State's Title V populations. The process also includes support of ongoing MCAH priorities and priority needs identified through the needs assessment process. The process includes consideration of public input, alignment with CDPH's strategic plan and priorities, availability of resources and the political will to address these factors. Given this multifaceted approach, California's Title V major state initiatives include the following:

>1115 Waiver, Promoting Organized Systems of Care for Children with Special Health Care Needs (CSCHN)
California's Medicaid Section 1115 waiver for hospital financing and uninsured care expires on August 31, 2010. The need to submit a new waiver application presents DHCS with an opportunity to transform the delivery of health care to children enrolled in CCS and provide services in a more efficient manner that improves coordination and quality of care through integration of delivery systems, uses and supports medical homes and provides incentives for specialty and non-specialty care.

As authorized by legislation (Assembly Bill (AB) x4 6, August 2009), DHCS has entered into a process to submit a new and comprehensive Section 1115 Medicaid waiver. This legislation sought to advance two policy objectives in restructuring the organization and delivery of services to be more responsive to the health care needs of enrollees to improve their health care outcomes and slowing the long-term rate of Medi-Cal program expenditures.

A Stakeholder Advisory Committee, as authorized in statute, consists of 39 individuals representing the populations for whom the delivery of care would be restructured through the waiver design -- seniors and persons with disabilities; CSHCN; individuals with eligibility for both Medi-Cal and Medicare and those in need of behavioral health care services. Reporting to the Stakeholder Advisory Committee are technical workgroups (TWG) constructed to discuss each of the populations and make recommendations to DHCS on what could be included in the 1115 Waiver that would improve the delivery of care for CSHCN. The CCS TWG workgroup has

assisted in specifically recommending several delivery models to pilot test in order to determine if any one of them can used to more effectively provide care for CCS clients. The CCS TWG has advised retention of the successful parts of the CCS program including quality standards and the network of providers.

Members of the CCS TWG represent families, provider organizations (American Academy of Pediatrics, Children's Specialty Care Coalition, California Association of Medical Product Suppliers, and California Children's Hospital Association); County CCS programs and County Health Administrators; foundations and Medi-Cal Managed Care health plans. The activities of the CCS TWG have been supported by the Lucile Packard Foundation for Children's Health. Specific information on the CCS TWG can be found at: http://www.dhcs.ca.gov/provgovpart/Pages/TechnicalWorkgroupCCS.aspx.

>Child Health Insurance Coverage
State legislation AB 1422, along with funding from the First Five Commission and program savings enacted by the Managed Risk Medical Insurance Board (MRMIB) will allow the Healthy Families (Program, California's low cost insurance for children and teens who do not qualify for Medi-Cal, to continue providing health care coverage to current enrollees.

From July 2003 through December 2009, over 4 million children receiving assessments were pre-enrolled for up to two months of no cost, full-scope Medi-Cal benefits. The number of families utilizing the CHDP via this process appears to gradually increase due to the number of families losing private health insurance due to the economy.

>Breastfeeding
Due to state budget cuts in August 2009, funds were reduced for the Birth and Beyond California (BBC) a hospital-based breastfeeding continuous quality improvement (QI) project which promotes model hospital policies to improve in-hospital exclusive breastfeeding rates. Funding continues for RPPC in L.A. to develop a report on BBC pilot project findings and provide technical assistance for all other RPPC regions for 2 years. To date, 20 hospitals fully participated and 2 of the funded RPPC regions have obtained other funds to continue the BBC work. BBC curricula and tools will be posted on the MCAH breastfeeding website.

MCAH is in the process of releasing 2008 in-hospital exclusive breastfeeding data. The fourth annual letter to hospital administrators is being prepared and will again include hospital data and links to resources to help hospitals improve their exclusive breastfeeding rate.

In December 2009, MCAH and the Women, Infants and Children (WIC) Supplemental Nutrition Program, in collaboration with the California Breastfeeding Coalition, and the California WIC Association began the California Breastfeeding Roundtable. The Roundtable met for the second time in June 2010 and has drafted a strategic plan that will be used by the CDPH Nutrition, Physical Activity and Obesity Prevention Program grant funded by the Centers for Disease Control and Prevention (CDC). MCAH has continued to have a staff person attend the US Breastfeeding Committee and be involved in its national promotion of workplace lactation support. MCAH has been advocating for a new CDPH lactation policy and piloting a bring-your-infant to work lactation supportive policy.

CCS is partnering with CPQCC in a breast milk nutrition quality improvement collaborative for 2010 involving 11 community and regional Neonatal Intensive Care Units (NICUs) with a goal of collaboratively improving by 25% any breast milk at discharge for <1500 gm infants. The baseline period is 10/1/08 through 9/30/09 and the intervention timeframe is 10/1/09 through 9/30/10. Each NICU has its own aim statement and is also collecting data on process and balancing metrics. In addition to monthly calls and exchanges via e-mail, there are three face-to-face learning sessions in 2010.

>Comprehensive Black Infant Health (BIH) Program assessment
MCAH places a high priority on addressing the persistent poor birth outcomes that disproportionately impact the African American community. MCAH has focused efforts to address social disparities to close the gap--BIH is central in these efforts.

In 2006, MCAH contracted with the University of California, San Francisco (UCSF) Center on Social Disparities in Health to complete an assessment report of the BIH Program that was released in 2008. The conclusions from the literature review of the report found no definitive scientific evidence showing the best path to decrease disparities, but current knowledge suggests promising directions by addressing: (1) health and social conditions (including stress) across the life course, (2) social support, (3) empowerment/capacity building of individuals and communities, and (4) group-based approaches. The report also found that the current BIH program models lacked standardization across sites and were out-dated. The data collection requirements also were not standardized, limiting the ability to measure the program's effectiveness.

The report recommended the development and implementation of a single core model for all local BIH program sites to enhance the impact on African American infant and maternal health. MCAH convened groups of key stakeholders including local BIH and MCAH staff, state MCAH staff, and UCSF Center on Social Disparities in Health staff to develop various aspects of the revised model and comprehensive evaluation plan. The revised model integrates the most current scientific findings, and state and national best practices. The revised model is strength-based and empowers the women to make better health choices for themselves and their families, and encourages broader community engagement to address the problem of poor birth outcomes. Services are provided in a culturally competent manner that respects clients' beliefs and cultural values.

The revised model will ensure linkages to prenatal care as well as empower women to improve their ability to manage stress related to the social, cultural, and economic issues that are known to influence health. The program starts with an intake that will assess clients' needs and identify strengths. There is an individual intervention that is primarily case management based on each client's identified needs. Central to this model is the 20 session group intervention (10 prenatal and 10 postpartum) that encourages and supports behaviors to help African American women become strong individuals and effective parents. The evaluation and data collection process has been fully revised to assess the program's effectiveness. In addition, MCAH has quality assurance measures in place to ensure the revised model's fidelity. In June 2010, a panel of national experts was convened to assess the new BIH model. The panel endorsed the concept; felt the model was scientifically supported and made recommendations for refinement.

Training on the new model and pilot implementation will be conducted at approximately half of the BIH sites in summer of 2010.

> Preconception Health
While the main goal of preconception care is to provide health promotion, and screening and interventions for women of reproductive age to reduce risk factors that might affect future pregnancies, MCAH takes a broader approach. Implicit in its Preconception Health and Health Care Initiative (PHHI) is a life course perspective that promotes health for women and girls across the lifespan, regardless of the choice to reproduce, and recognizes the impact of social and environmental factors on maternal and infant outcomes. MCAH partners with organizations and stakeholders across the state to provide direction for the integration of preconception care into public health and clinical practice, develop policy strategies to support preconception care and promote preconception health messaging for women of reproductive age.

PHCC, established in 2006 through a partnership between MCAH and the March of Dimes, remains at the center of preconception health activities in the state. In May 2009, the PHCC launched a comprehensive preconception health website--Every Woman California. Supported with Title V funds, the website features information about health considerations for women of

childbearing age --including low-literacy PDFs on 21 preconception health topics -- as well as resources, tools and best practices for providers. The website has a partner registration feature to encourage networking and resource sharing among those interested in preconception health and health care and features interactive event calendars and discussion forums: http://www.everywomancalifornia.org.

Other preconception health activities spearheaded by MCAH include a folic acid awareness campaign implemented in early 2009. Designed to address findings showing lower rates of folic acid consumption among Latinas and women of lower education attainment in California, the campaign featured Spanish language radio Public Service Announcements (PSAs); outreach to the community through health promoter training; and vitamin distribution and education through local public health programs. It resulted in a 1200% increase in calls to referral line and 45,000 bottles of vitamins distributed.

California MCAH was a recipient of First Time Motherhood grant funds from Health Resources and Services Administration (HRSA)/MCHB to implement a preconception health social marketing campaign. California's project will test "preconception health" and "reproductive life planning" messages and message delivery mechanisms, including web- and mobile-based strategies, with different populations, especially African-American women, Latinas and youth of color. The campaign will place preconception health and reproductive life planning in a life course context and address broader societal influences on health. MCAH will be working on this campaign through early 2011.

MCAH staff continues to participate in a number of national preconception health--related workgroups including the national preconception health indicators workgroup and the CDC's preconception health consumer workgroup.

The PHCC serves as a coordinating hub for preconception health activities across the state such as the Interconception Care Project of California, an American Congress of Obstetrics and Gynecologists (ACOG), Region 9 project funded by March of Dimes that is charged with developing postpartum care visit guidelines for obstetric providers. The goal of the project is to provide physicians with the tools needed to address issues at the post-partum visit that could affect a subsequent pregnancy and counsel the patient about plans for future children.

Local MCAH health jurisdictions have also undertaken activities related to preconception health. The L.A. Collaborative to Promote Preconception/Interconception Care has produced a curriculum for public health providers; published a data brief on preconception health in LA County; established a website; held a second preconception health summit for providers in the county; and developed an evaluation framework for the collaborative. It also oversees local preconception health projects that have had promising results such as the California Family Health Council's effort to develop and introduce a pre/interconception care curriculum into nearly 80 Title X clinics and the Public Health Foundation Enterprises WIC's WOW project (WIC Offers Wellness) which extended its integration of interconception health into WIC from one center to 61 centers throughout L.A. and Orange County.

>High-Risk Infants

The High Risk Infant Follow-up Program (HRIF) screens babies who might develop CCS-eligible conditions after discharge from a NICU and assure access to quality specialty diagnostic care services. All CCS-approved NICUs are required to have a HRIF Program or a written agreement for services by another CCS-approved HRIF Program.

In 2006, CCS redesigned HRIF and started the Quality of Care Initiative (QCI) with CPQCC. The QCI developed a web based reporting system to collect HRIF data to be used in quality improvement activities. As of March 1, 2010, 60 of the 74 CCS-approved HRIF Programs are reporting on-line, with a reporting of over 2,000 HRIF Program referrals and 1500 HRIF Program visits.

>Neonatal Quality Improvement Initiative
CMS and the California Children's Health Association (CCHA) sponsored a statewide QI Collaborative, partnering with CPQCC, to decrease Central Line Associated Blood Stream Infections (CLABSIs) in NICUs using the Institute for Healthcare Improvement (IHI) model for QI. Thirteen regional NICUs participated in 2006-07, reducing CLABSIs by 25 percent for all weight groups. In the second year, all 22 Regional NICUs participated, aided by a Blue Shield Foundation grant. The CLABSI rate in 2008 was 2.33 per 1000 line days and 3.22 in 2007, but some of this reduction was due to a CDC definitional change for CLABSIs beginning Jan. 1, 2008. After the grant extension ended June 30, 2009, 14 regional NICUs continued the CLABSI prevention collaborative and for 2010 they are adding bloodstream infection (BSI) prevention. For 2009 the CLABSI rate for the 14 NICUs was 2.05 for all weights, and competing priorities have been the greatest barrier to infection prevention.

>Pediatric Critical Care
CMS has structured a system of 21 CCS-approved pediatric intensive care units (PICUs) to assure that infants, children and adolescents have access to appropriate quality specialty consultation and intensive care services throughout the state. CCS sets standards for all CCS-approved PICUs and periodically conducts PICU site visits to help ensure standards are followed. Included in the standards is a requirement to submit annual morbidity/mortality data to CCS.

CMS and the University of California, Davis conducted a survey of PICU medical directors to assess the infrastructure for Pediatric Critical Care quality care and the need for statewide benchmarking standards to direct QI efforts. CMS will focus on collaboration with PICU leadership in developing a statewide data collection and reporting system for QI purposes.

>Pediatric Palliative Care
CMS submitted a 1915(c) waiver to the Centers for Medicare and Medicaid Services which was approved December 2008. Many stakeholders across California and in other states participated in the development of the waiver program. The program, which began to enroll children in January 2010, allows Medi-Cal clients to receive hospice-like services at home while concurrently receiving curative treatments. The program partners with hospice and home health agencies to provide a range of services to improve the quality of life for eligible children and their families including care coordination, family training, expressive therapies, respite care and bereavement counseling for caregivers. The initial three year program started in five counties: Alameda, Monterey, Santa Cruz, Santa Clara, and San Diego, and will expand to 13 counties by the third year.

>Maternal Health
Maternal mortality has doubled in California since 1998 to 16.9 deaths per 100,000 live births in 2006, well above the Healthy People 2010 benchmark of 4.3 deaths per 100,000 live births. African-American women were roughly four times more likely to die from pregnancy-related causes with 46.1 deaths per 100,000 live births compared to 12.9 for Hispanic women, 12.4 for White women and 9.3 for Asian women. Subsequently, MCAH has supported diverse efforts to identify and address factors that appear to be contributing to increasing rates of maternal morbidity and mortality in California under the "Safe Motherhood" initiative.

First, MCAH gathers and manages statewide and local data needed to analyze factors related to poor birth outcomes and perinatal morbidity and mortality such as the Maternal Infant Health Assessment (MIHA) and California Women's Health Survey (CWHS). MCAH conducts the California Pregnancy Associated Mortality Review (PAMR) which is the first statewide fatality review of maternal deaths in California. Pregnancy-related deaths from 2002 and 2003 have been reviewed and a report on findings is in development. The Maternal Quality Indicator Work Group (MQI) trends maternal morbidity data and tests methods for monitoring national obstetric quality measures in California.

Secondly, MCAH promotes a regionalized approach to create collaborative networks of care and ensure that patients access care appropriate to their level of risk. RPPC is a statewide regional network that provides consultation to all delivery hospitals. RPPC uses current statewide and hospital-specific outcomes data to implement strategies to improve risk-appropriate care for mothers and their babies and collaborates with perinatalogists for high-risk mothers and their infants. The California Perinatal Transport System (CPeTS) facilitates transport of mothers with high-risk conditions and critically ill infants to regional intensive care units as well as collecting transport data for regional planning and outcome analysis. MCAH also provide support for local programs to improve maternal health through maternity care improvement projects (Local Assistance for Maternal Health). Currently, San Bernardino County is providing leadership to reduce non-medically indicated labor induction with anticipated health benefits to mother and infant. L.A. County is leading a collaborative effort to improve hospital response to obstetrical hemorrhage, a leading cause of maternal morbidity and mortality.

Thirdly, MCAH has developed a Maternal Health Framework (MHF) to guide program development, including improvements for current programs and opportunities to create new programs. The MHF considers social and ecological contributing factors to maternal health in 3 phases of a life course perspective: prior to pregnancy, during pregnancy and following pregnancy to restore a mother to health should a health complication arise during pregnancy.

For Phase I, the Preconception Health programs (described elsewhere) are focusing on maximizing health of women and girls of reproductive age before they get pregnant. Some programs target pregnant women with the goal of maximizing health during pregnancy.

For Phase II, the BIH program addresses health disparities for African-American mothers and children by facilitating access to prenatal care and providing health education and social support services to mothers. CPSP provides enhanced prenatal services to meet nutrition, psychosocial and health education needs of clients. AFLP provides case management and education to pregnant and parenting adolescents to promote healthy pregnancy outcomes, effective parenting and socioeconomic independence. The Office of Family Planning (OFP) provides comprehensive education, family planning services, contraception and reproductive health services with the goal of reducing unintended pregnancies and optimizing maternal health prior to pregnancy.

Finally, in Phase III, MCAH provides programs and services to address common complications of pregnancy. CDAPP recruits, educates and provides consultation and technical assistance to providers who deliver comprehensive health services for high-risk pregnant women with pre-existing diabetes or women who develop diabetes while pregnant. CMQCC has developed two QI toolkits: one to reduce morbidity of obstetrical hemorrhage, a common complication of pregnancy and one to reduce elective inductions of labor prior to 39 weeks gestation which appears to be associated with higher rates of cesarean delivery.

WIC contributes to optimizing health outcomes throughout all three phases of the MHF. WIC accomplishes this by linking families to local community and public health services and by providing lactation support, nutrition education and nutritious food to low income pregnant women, new mothers and children.

>Data and Surveillance

In 2010, MCAH began collaborating with WIC on several applied, public health research projects. The goal of the first project is to combine WIC program data with data from the Birth Statistical Master File and with data from MCAH programs in order to identify areas in California where there is a need for WIC services, to identify opportunities to better target WIC services to MCAH populations, and to evaluate outcomes associated with the receipt of WIC services. GIS and hot-spot maps will be used to examine results at local levels. Second, California's Maternal and Infant Health Assessment (MIHA) Survey will be expanded in 2010. The sample size will increase and women who are eligible for, but not on WIC, will be oversampled. MIHA data will allow for the analysis of attitudes, risk factors, and behaviors of recent mothers relating to pregnancy

outcomes and the child's early infancy, as well as the analysis of WIC clients and income-eligible clients not on WIC. Specifically, the data will be used to produce state- and select county-level descriptions of income-eligible women who are not enrolled in WIC, descriptions of WIC participants, and a statewide evaluation of WIC impact. Both of these efforts will help WIC better target and allocate resources and are necessary to fulfill mandated federal reporting requirements.

Over the past year, MCAH has also collaborated with CDC to develop seven proposed Healthy People 2020 measures, which will combine data from the Pregnancy Risk Assessment Monitoring System (PRAMS) and MIHA. PRAMS has not been used as a data source for HP indicators in the past because without California it did not represent a large enough proportion of births. The combined estimates will allow tracking of key MCAH indicators, including infant sleep position, substance use and weight gain during pregnancy, postpartum smoking, and preconception/interconception care, many of which are otherwise unavailable from other data sources, and will represent approximately 85% of all births in the United States.

2010 marks the 6th series of regional workshops to improve birth data quality on the birth certificate. Since 2004, the Office of Vital Records and MCAH have collaborated to plan Birth Data Quality Workshops across California. Joint meetings target area hospitals with missing data and RPPC leaders are recruited to assist with presentations supporting staff who collect birth data to better understand the items on the birth certificate, definitions of medical terms listed, and how the data helps to improve care for women and their infants. To accomplish this we bring together local and state birth registrars, county MCAH Directors, local hospital administration, perinatal nursing staff, medical records and birth data collection staff, and we recognize hospitals for improvement and high achievement.

B. Agency Capacity

California has a statewide system of programs and services that provides comprehensive, community-based, coordinated, culturally competent, family-centered care. For example, Special Care Centers (SCCs) and hospitals that apply to become CCS-approved must meet specific criteria for family-centered care (FCC). FCC is assessed by the CMS Branch as part of the ongoing review process of CCS-approved SCCs and hospitals. Local CCS programs facilitate FCC by assisting families to access authorized services, such as pediatric specialty and subspecialty care, and by providing reimbursement for travel expenses, meals, and motel rooms during extended hospital stays.

MCAH and CMS Programs

MCAH and CMS programs provide direct services, enabling services, population-based services and/or infrastructure-building services. A table is attached as a guide to identify the lead agencies with which these programs are affiliated, the primary population these programs target pregnant women; mothers and infants; children, adolescents and CSCHN) and the availability of the program at the local or community level. These programs were created or permitted by statute and include the following:

>Adolescent Family Life Program (AFLP)

AFLP aims to promote healthy development of adolescents and their children, healthy lifestyle decisions, including immunization and pregnancy prevention and continuation of adolescents' education. It uses a case management model to address the social, medical, educational, and economic consequences of adolescent pregnancy, repeat pregnancy and parenting on the adolescent, her child, family, and society. It also links clients to mental health, drug and alcohol treatment, foster youth, family planning and dental care services and direct services available through Medi-Cal and CalWorks. AFLP targets services to pregnant and parenting teens and is providing services to approximately 6000 adolescents in 38 programs throughout the State. In

many counties, AFLP is the only case management program available for pregnant and parenting teens.

>Black Infant Health (BIH)
BIH which has the goal of reducing African American infant mortality in California uses case management and group interventions to support African American women in their pregnancies and improve birth outcomes. The BIH program is currently serving approximately 3000 women in 16 programs in the State.

>California Birth Defects Monitoring Program (CBDMP)
CBDMP collects and analyzes data to identify opportunities for preventing birth defects and improving the health of babies. The 2006 birth year information was recently linked to vital statistics live birth and fetal death information, creating a database of more than 129,000 pregnancies affected with birth defects from a base population of 6.25 million births. Birth year 2007 linkage will be completed soon.

>California Children's Services (CCS) Program
CCS provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with CCS-eligible medical conditions. Examples of CCS-eligible conditions include, but are not limited to, chronic medical conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries, and infectious diseases producing major sequelae.

The program authorizes medical and dental services for CCS-eligible conditions, establishes standards for providers, hospitals, and SCCs for the delivery of care, and provides physical and occupational therapy and medical case conference services at selected public school sites for children with specific medically eligible conditions. Thirty-one "independent" counties fully administer their own CCS programs, and 27 "dependent" counties share administrative and case management activities with CMS Branch Regional Offices. Social Security Income (SSI) beneficiaries with a CCS medically-eligible diagnosis are served by the CCS program

CCS has a regional affiliation system with 114 CCS-approved NICUs. NICUs providing basic level intensive care services are required to enter in to a Regional Cooperation Agreement (RCA) with NICUs that provide more extensive services, to facilitate consultation and patient transfers as needed. CCS approves the designated level of patient care (Intermediate, Community and Regional) provided in each NICU, and verifies that the RCA is in place. Starting with 2004 data, all CCS NICUs are required to submit their CCS data through CPQCC.

>California Diabetes and Pregnancy Program (CDAPP)
CDAPP promotes optimal management of diabetes in at-risk women, before, during and after pregnancy. Regional teams of dietitians, nurses, behavioral specialists and diabetic educators provide training and technical assistance to promote quality care provided by local Sweet Success providers and to recruit and train new Sweet Success providers in areas of need.

>California Early Childhood Comprehensive Systems (ECCS)
ECCS promotes universal and standardized social, emotional and developmental screening. ECCS collaborative efforts provide the Child Health and Disability Prevention (CHDP) Program with guidance on validated and standardized development/social-emotional health screening tools for earlier identification of children with developmental delays. The revised guidelines were an important collaboration between CHDP and the MCAH led team of the national Assuring Better Child Health and Development (ABCD) Screening Academy Project. The work to enhance California's capacity to promote and deliver effective and well-coordinated health, developmental and early mental health screenings for young children, ages 0-5, continues through the Statewide Screening Collaborative, which served as the stakeholders in the ABCD project.

ECCS is partnering with Alameda County to develop early childhood programs of care for children 0 to 8 years of age California Project Launch.

>Child Health and Disability Prevention (CHDP) Program
CMS administers the screening component of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, called the CHDP Program. CHDP provides preventive services and referral to diagnostic and treatment services for Medi-Cal participants up to age 21. Uninsured children up to age 19 in households at or below 200% of the FPL can pre-enroll in Medi-Cal through the Gateway process

CHDP provides complete health assessments for the early detection and prevention of disease and disabilities for low-income children and youth. A health assessment consists of a health history, physical examination, developmental assessment, nutritional assessment, dental assessment, vision and hearing tests, a tuberculin test, laboratory tests, immunizations, health education/anticipatory guidance, and referral for any needed diagnosis and treatment.
>Comprehensive Perinatal Services Program (CPSP)
CPSP provides comprehensive perinatal care including obstetrical, nutrition, health education, and psychosocial services from qualified providers to Medi-Cal eligible women. There are 1566 active CPSP providers in California. MCAH develops standards and policies; provides technical assistance and consultation to the local perinatal services coordinators; and maintains an ongoing program of training for all CPSP practitioners throughout the state. Local MCAH staff offer technical assistance and consultation to potential and approved providers in the implementation of CPSP program standards.

>Fetal Infant Mortality Review Program (FIMR)
Sixteen local health jurisdictions have FIMR Programs that enable them to identify and address contributing factors to fetal and infant mortality. A Case Review Team examines selected fetal and infant death cases, identifies factors associated with these deaths, and determines if these factors represent systems problems. Recommendations from the Case Review Team are presented to a Community Action Team that develops and implements interventions that lead to positive changes.

>Genetically Handicapped Persons Program (GHPP)
GHPP provides case management and funding for medically necessary services to people with certain genetic conditions. Most GHPP clients are adults, but 4.6 percent are children under 21 years. The GHPP serves eligible children of higher family incomes who are ineligible for the CCS program.

GHPP client enrollment is stable, with 1750 clients for 2008-2009.

> Hearing Conservation Program (HCP)
HCP helps to identify hearing loss in preschoolers to 21 years of age in Public Schools. All school districts are required to submit to CMS an annual report of hearing testing.

>Health Care Program for Children in Foster Care (HCPCFC)
HCPCFC is a public health nursing program located in county child welfare service agencies and probation departments to provide public health nurse expertise in meeting the medical, dental, mental and developmental needs of children and youth in foster care

>High Risk Infant Follow-up (HRIF)
Infants discharged from CCS-approved NICUs are followed in NICU HRIF clinics. Three multidisciplinary outpatient visits are authorized by CCS up to age three to identify problems, provide and complete referrals, and monitor outcomes.

The HRIF program continues to provide three multidisciplinary outpatient visits to identify

problems, institute referrals, and monitor outcomes. The QCI developed a web based reporting system to collect HRIF data for quality improvement activities. Statewide trainings were provided to all NICU and HRIF Program staff before implementation and a follow-up training was held in February 2010.

>Human Stem Cell Research Program (HSCR)
HSCR develops comprehensive guidelines to address the ethical, legal, and social aspects of stem cell research and ensure the systematic monitoring and reporting of HSCR activity that is not fully funded by Proposition 71 money granted through the California Institute for Regenerative Medicine. A diverse group of 13 national and international specialists serve on a HSCR Advisory Committee to advise CDPH on statewide guidelines for human stem cell research.

>Local Health Jurisdiction (LHJ) Maternal Child and Adolescent Health Programs (LHDMP)
61 LHJs receive Title V allocations that support local infrastructure, including staff, to conduct culturally sensitive collaborative and outreach activities to improve services for women and children, refer them to needed care, and address state and local priorities for improving the health of the MCAH population.

>MCAH Toll-free Hotline
MCAH staff responds to calls and refer callers to local MCAH programs. LHJs also have local toll-free numbers that provide information and referrals to clients. Local MCAH contact information is made available online.

>Medical Therapy Program (MTP)
MTP provides physical and occupational therapy services to children with CCS MTP eligible conditions. There is no financial eligibility requirement. MTP conducts multidisciplinary team conferences to support case management and care coordination. The number of clients enrolled in the MTP has shown a slight declining trend over the past 5 years of 7% and is currently 24,777(25,556 in 2010).

>Newborn Hearing Screening Program (NHSP)
NHSP helps identify hearing loss in infants and guide families to the appropriate services needed to develop communication skills. In California, 243 hospitals are certified to participate in the NHSP as of December 2009.

>Pediatric Palliative Care Waiver Program
This program allows for the provision of expanded hospice type services and curative care concurrently. This program is designed to improve the quality of life for children with life limiting or life threatening conditions, and their family members. It is anticipated that cost neutrality will be achieved by reduced hospital stays, medical transports and emergency room visits in addition to other costs avoided while the child is enrolled in the program.

>Regional Perinatal Programs of California (RPPC)
RPPC promote access to risk-appropriate perinatal care to pregnant women and their infants through regional QI activities. RPPC facilitate local perinatal advisory councils to provide regional planning, coordination, and recommendations to assure appropriate levels of care. In addition the local perinatal advisory councils perform hospital surveys and perinatal assessments of regional and statewide significance; develop communication networks locally; disseminate educational materials and produce a statewide newsletter; provide resource directories, referral services, and hospital linkages to the Northern and Southern CPeTS; and assist hospitals with QI activities, data collection protocols, and quality assurance policies and procedures.

CPeTS maintains a web-based bed availability list, locate beds for high-risk mothers and infants and provide transport assistance, transport data reports, and perinatal transport quality improvement activities, including emergency triage and transport in the event of a disaster. Maternity hospitals can obtain information 24 hours a day, 7 days a week to facilitate transfers.

>Sudden Infant Death Syndrome (SIDS) Program
SIDS is funded in all 61 LHJs to provide support to families that experience a SIDS death, conduct prevention activities, and enable staff to attend annual training. The SIDS Program provides statewide technical assistance and support to healthcare and public safety personnel and parents including education about SIDS, grief counseling, and information on prevention to reduce the risk of SIDS.

MCAH places high priority on providing stakeholders and partners with quality assistance where necessary to improve MCAH program performance. The following programs were created to address the developmental assistance needs in the state:

>Breastfeeding Technical Assistance Program
This program promotes and supports efforts to make breastfeeding the infant feeding norm. Its website (http://www.cdph.ca.gov/programs/breastfeeding/Pages/default.aspx) contains targeted breastfeeding information for families and providers. It has piloted the Birth and Beyond California to assist hospitals to improve their exclusive breastfeeding rates and collaborated with MediCal, WIC and the CA Breastfeeding Coalition to improve hospital support for breastfeeding.

>Oral Health Technical Assistance Program
Oral Health Program provides local technical assistance and state level coordination and collaboration to address the oral health needs of pregnant women, mothers, children and adolescents, especially within low-income families, by expanding access to dental care and preventive services, and by encouraging local MCAH Programs to work in collaboration with new and existing dental and health-related programs. This year, 18 local MCAH programs have chosen oral health as a priority objective. Another 25 local MCAH programs collaborate on various community tasks forces involving oral health issues. Further direction has been provided by updating oral health educational components in the CPSP "Steps to Take" Guidelines, BIH perinatal and postpartum curriculums, AFLP "Infant Feeding" Guidelines and CDAPP's Sweet Success Guidelines.

>Preconception Health and Healthcare
MCAH is partnering with organizations and stakeholders across the state to provide direction for the integration of preconception care into public health practice, develop policy strategies to support preconception care, and promote preconception health messages to women of reproductive age.

Major Collaboratives
MCAH and CMS value the input provided by its stakeholders across communities and has actively fostered collaboratives, task forces and advisory/work groups to address MCAH and CSCHN health issues. These collaborative, task forces and advisory/work groups also serve to coordinate preventive and health care delivery with other services at the community level as well as with the health components of community-based systems. These include the following:

> Adolescent Sexual Health Work Group (ASHWG)
ASHWG is a collaborative of 23 organizations from CDPH, CDE and non-governmental organizationss who address sexual and reproductive health needs of youth. Its vision is to create a coordinated, collaborative, and integrated system among government and non-government organizations to promote and protect the sexual and reproductive health of youth in California. Current activities focus on core competencies for providers and educators , integrated data tables (available at: http://www.californiateenhealth.org/download/ASHWG_Integrated_Data_Tables.pdf) and youth development.

>California Perinatal Quality Care Collaborative (CPQCC)
CPQCC is a cooperative effort of public and private obstetric and neonatal providers, insurers, public health professionals and business groups. It develops perinatal and neonatal quality

improvement infrastructure at state, regional, and hospital levels. For 2010, CPQCC membership is at 128 NICUs, with all of the 114 CCS-approved NICUs as members.

The Perinatal Quality Improvement Panel (PQIP), is a standing subcommittee of CPQCC, that provides oversight for all quality functions of CPQCC by creating, initiating and conducting statewide quality projects and/or prospective trials; publishing and disseminating new and updated QI toolkits; analyzing the CPQCC database and designing supplemental data collection tools; and initiating and implementing research projects focused on QI.

> California Maternal Quality Care Collaborative (CMQCC)
CMQCC is the statewide umbrella organization for assessing the current state of knowledge of maternal illness and complications and transforming this knowledge into targeted, evidence-based, data-driven clinical quality improvement interventions and public health strategies statewide and at the local level. CMQCC's mission is to end preventable maternal morbidity and mortality by improving the quality of care women receive during pregnancy, childbirth, and postpartum. CMQCC maintains an informative website of resources and policies for both public and private use (www.cmqcc.org) and provides educational outreach to health professionals.

Family Voices of California (FVCA)
FVCA helps CSCHN families through a coordinated network of regional, family-run FVCA Council Member agencies. FVCA continues to provide information to families and professionals on issues relating to a Medical Home, including organizing healthcare information and navigating health systems.

FVCA collaborated with DHCS and other partners on various committees, taskforces, senate hearings, and stakeholder groups related to 1115 Waiver, CCS redesign, and the Title V Needs Assessment. FVCA has ensured that parents and community members are involved in these processes, has provided financial support to families to enable their involvement, and has facilitated providing parent and community member input through key informant interviews and focus groups.

>Prenatal Substance Use Prevention
MCAH's efforts related to perinatal substance use prevention are conducted through partnerships and collaboration. MCAH representatives participate in the California Fetal Alcohol Syndrome Disorder (FASD) Task Force, an independent, public-private partnership of parents and professionals from various disciplines committed to improving the lives of Californians affected by FASD and eliminating alcohol use during pregnancy. MCAH also participates in the State Interagency Team FASD workgroup, composed of members from the MCAH, Department of Social Services (DSS), Department of Mental Health (DMH), California Department of Education (CDE) , Department of Developmental Services (DDS) and ADP acting as lead. The goal of the workgroup is to identify interagency and systems issues that provides potential opportunities for prevention/intervention of FASD.

MCAH LHJs have identified perinatal substance use prevention as a priority. They have engaged in community mobilization and capacity building, and implemented screening, assessment, and referral to treatment programs that address their particular needs.

>Preconception Health Council of CA
One of the key ways that MCAH partners with other entities is through PHCC which was established in 2006 by MCAH and the MOD, California Chapter. In May 2009 the PHCC launched its official website: www.everywomancalifornia.org, which is supported by Title V funds. The website contains information for both consumers and providers and includes an interactive section for health professionals featuring discussion forums, opportunities for networking and resource-sharing, and an event calendar. MCAH also received a First Time Motherhood grant from HRSA/MCHB to develop a preconception health social marketing campaign reaching women at increased risk for poor pregnancy outcomes.

>Transition Workgroup
CMS recognizes the importance of transitioning health care for CSHCN from pediatric to adult services. During site reviews of new SCCs and CCS programs, the issue of health care transition planning and age and developmentally appropriate care for CSHCN is reviewed and discussed.

CMS formed a statewide Transition Workgroup comprised of healthcare professionals, experts in transition care, former CCS clients and family representatives who worked together on the Branch's Transition Health Care Planning Guidelines for CCS programs. The Guidelines were released in 2009, as a CCS Information Notice.

CMS collaborates with the California Health Incentives Improvement Project (CHIIP) and funded by the Medicaid Infrastructure Grant from the Centers for Medicare and Medicaid Services. As staffing allows, CMS will participate on the CHIIP Youth Transition Advisory Committee.

Business Partners
To further enhance current capacity to provide community based preventive and health care services, expertise in health related services through provision of technical assistance is improved via contractual relationships with clinical and academic health experts. These include:

>Branagh Information Group
CAH contracted with the Branagh Information Group to develop, maintain and provide technical assistance for LodeStar, a comprehensive software package for AFLP agencies conducting case management for pregnant and parenting teens and their children. Branagh Information Group also was contracted to develop and maintain BIH Management Information Services (MIS), a software package for BIH agencies conducting case management.

>The California Adolescent Health Collaborative (CAHC)
MCAH has a contract with CAHC to provide adolescent health expertise, address current adolescent health concerns through technical assistance to the local MCAH programs and other partners. CAHC also supports core activities of ASHWG.

>California State University, Sacramento (CSUS)
CSUS provides CPSP Provider Training, is developing on-line provider training, and supports statewide CPSP meetings.

>Childhood Injury Prevention Program (CIPP)
To reduce injury-related mortality and morbidity among children and adolescents, MCAH contracts with the Center for Injury Prevention Policy and Practice (CIPPP) at San Diego State University. CIPPP provides technical support for local MCAH programs and their partner agencies via face to face meetings, tele-conferences, e-mail, a list serve, and literature reviews of the latest injury prevention research.

>Family Health Outcomes Project (FHOP) at the University of California, San Francisco
FHOP provides technical assistance and training, analyzes data for LHJs, provides a current web listing of useful resources, assists in establishing guidelines, and prepares special state reports for MCAH and CMS.

>Health Information Solutions
With direction from MCAH, Health Information Solutions developed and maintains the Improved Perinatal Outcomes Data Reports (IPODR) website. IPODR allows users to view and download the most recent demographic and hospital data about California mothers and infants. The data are available in tables for the most recent year available, in maps aggregating the past three years, and in graphs displaying a 15-year trend. Information is available at the state, county, and zip code levels.

>Perinatal Profiles at the School of Public Health, University of California at Berkeley
This project produces an annual report that provides information on sentinel indicators of perinatal quality care for all the maternity hospitals and regions in California that may reveal where efforts are needed for the purpose of continuous quality improvement.

>Maternal and Infant Health Assessment (MIHA) with the Center on Social Disparities in Health, University of California in San Francisco
MIHA is an annual survey that collects population-based information about maternal health status, health behavior, knowledge, and experiences before, during and shortly after pregnancy. Findings are disseminated through conference presentations, reports and posting of survey results through the MCAH website.

Select Statewide Programs Serving the MCAH Population
Medi-Cal and HF provide California's low-income children with access to comprehensive primary and preventive services, including dental care. Medi-Cal covers children ages 1 through 5 living in household up to 133% of FPL, children and adolescents ages 6 to 19 at up to 100% of FPL, and young adults ages 19 to 21 at up to 86-92% of FPL. HF covers children up to age 18 who are uninsured and in households up to 250% of FPL. Monthly premiums and co-payments for certain types of visits and prescriptions are required.

As of January 2010, there were 878,005 children enrolled in HF, an approximately 1.6% decrease from the previous year. Of those children, approximately 2.9% (25,878) are being served by CCS for their special health care needs.

Specific to infants, Medi-Cal, HF and AIM provide health insurance for infants. Medi-Cal reaches infants in households below 200% of FPL. HF reaches infants in households up to 250% of FPL; monthly premiums and co-payments are required. AIM provides state-subsidized third party insurance for infants in households at 200-300% of FPL.

State law requires MRMIB to enroll infants of AIM mothers into HF. AIM infants above 250% will be able to continue in HF up to 2 years of age before having to meet current eligibility. As of January 2010, CCS serves 418 AIM children.

Rehabilitation services
Services such as physical therapy for SSI beneficiaries under the age of 16 with a CCS medically-eligible diagnosis are served by MTP. Children with mental or developmental conditions receiving SSI are served by the DMH, DDS and CDE. In FY 2009-2010, CCS received 86 referrals. Of these, five were not medically eligible for CCS and two could not be verified. CCS will continue to work with the Disability Evaluation Division to train local staff to conduct CCS medical eligibility evaluations which should result in fewer referrals to CCS.

Family-centered, community-based coordinated care (FCC) for CSHCN
SCCs and hospitals that treat CSHCN who wish to become CCS-approved must meet specific criteria for FCC. FCC is assessed and recommendations are made as part of the review process by the CMS Branch.

CCS facilitates FCC services for families of CSHCN. CCS allows a parent liaison position in each county CCS program to enable FCC. County programs assist families to access authorized services, such as pediatric specialty and subspecialty care, and provide reimbursement for travel expenses, meals, and motel rooms during extended hospital stays. Many county CCS programs are terminating parent liaison contracts due to state budget cuts.

In 2009 the Children's Regional Integrated Service System (CRISS) annual family-centered care conference focused on mental health services for children and youth with special health care needs. The conference was co-sponsored with the University Center on Excellence in Developmental Disabilities (UCEDD), Family Voices of California, and CMS.

The CRISS NICHQ project to promote medical homes for children with epilepsy in a Sonoma County Federally Qualified Health Center was completed in 2009. CRISS worked with the Sonoma County CCS program to take on responsibility for continuing to convene the project's local oversight committee, and the Federally Qualified Health Center (FQHC) is continuing activities to support medical homes for children with epilepsy.

Additionally, CRISS makes the parent health notebook and other medical home materials available on its website www.criss-ca.org.

L.A. Partnership for Special Needs Children (LAPSNC), which promotes parent involvement in meetings and on committees, cosponsored an all day conference entitled "Weathering Difficult Times: Resources for Children with Special Needs and their Families". Parents served on the planning committee for this meeting and 130 providers and parents were in attendance.

FVCA continues its active role as a significant resource for families and professionals on issues relating to a medical home, including organizing healthcare information and navigating health systems.

In 2009, FVCA created a youth council, Kids As Self Advocates (KASA), that meets once a month via conference call and face to face every other month. CCS has attended some of the KASA meetings, and KASA youth have provided input to CCS on transition issues. KASA youth have received leadership training, and FVCA provides staff time for a youth group coordinator and provides youth with stipends for participation at meetings and travel.

In addition to youth leadership training, FVCA is developing the FVCA Parent Leadership Training Curriculum to prepare families to partner in decision-making and has piloted trainings at the annual Family Resource Supports Institute.

In 2009, FVCA was a collaborative member of "Partners in Policymaking" and worked to provide leadership training to 35 self-advocates and parents of children with developmental disabilities in L.A. County. The 2010 training will be in San Bernardino County.

Over the last eight years, FVCA in collaboration with advocates across the state convened annual statewide Health Summits that have brought together families, professionals, agency representatives, advocates, insurers, health policy experts and legislators to discuss access to affordable and appropriate health care for CSHCN and to develop strategies to address the challenges families face. FVCA funds this conference through its federal MCHB grant and private sponsors, thus providing families with travel scholarships and stipends to be able to attend.

Other FVCA 2009 activities have included: Council's monthly meetings to address parent and community involvement; hosting 9 statewide webinars for families and professionals on topics such as the Family Opportunity Act, health care transition, nutrition for CSHCN, and impacting legislators; and participation in the Prematurity Coalition's Summit, providing and organizing a panel on Home Based Community Care to address parent and community involvement during and after hospital stays for families with babies born prematurely.

In 2009 and 2010, FVCA collaborated with DHCS and other partners on various committees, taskforces, senate hearings, and stakeholder groups related to 1115 Waiver, CCS redesign, and the Title V Needs Assessment, ensuring that parents and community members are involved in these processes. FVCA has provided financial support to families to enable their involvement, and has facilitated parent and community member input for interviews, focus groups, and surveys.

Approaches to Culturally Competent Service Delivery
Because California is a cultural melting pot, it is paramount that both MCAH and CMS interact

and provide services in a culturally, linguistically and developmentally competent manner with people of diverse backgrounds. Both MCAH and CMS value and respect the diversity of clients our programs serve. Developing cultural competence results in an ability to understand, communicate with, and effectively interact with people across cultures. Both MCAH and CMS have mechanisms to promote culturally and linguistically competent approaches to service delivery such as:

? BIH delivers culturally competent services to address the problem of disproportionate mortality in African American infants.

? The Local MCAH Scope of Work requires local programs to report whether their staff has received training in cultural competency.

? MCAH and CMS collect and analyze data according to race, ethnicity, age, etc. to identify disparities.

? MCAH and CMS program materials are mostly published in English and Spanish, and translated to other languages as needed

? FIMR has posted a guide and tool on the MCAH website for assessing cultural and linguistic competence among their funded agencies

An attachment is included in this section.

An attachment is included in this section.

C. Organizational Structure

Arnold Schwarzenegger is the Governor of California, a position he has held since November 2003. S. Kimberly Belshé is the Secretary for the California Health and Human Services Agency (CHHSA), which is a cabinet-level position that reports directly to the Governor. Mark B. Horton, MD, MSPH is the Director of the CDPH, which is one of thirteen departments in CHHSA together with the DHCS. David Maxwell-Jolly, Ph.D. is the Director of DHCS.

The State of California designates CDPH to administer the MCAH Program.[27, 28] MCAH has the primary responsibility for carrying out Title V functions, the MCAH program, and other similar programs that include the HSCR and Cord Blood Banking Program and CBDMP. MCAH reports directly to CDPH's CFH, which is one of five centers responsible for carrying out CDPH's core activities.[29] Catherine Camacho is the Deputy Director of CFH, a position she's held since CDPH was established in July 2007.[30] Vickie Orlich is the Assistant Deputy Director for CFH.

MCAH coordinates with DHCS' CMS Branch to handle Title V activities related to CSHCN.

Information about MCAH is provided in the sub-sections below. Information about CMS Branch is available in Section III D. For updated organizational charts for MCAH and CMS Branch, see the attachments to Sections III C and III D, respectively.

>Maternal Child and Adolescent Health Program (MCAH)

Shabbir Ahmad, PhD, has acted as Chief of MCAH since June 2007. Les Newman is the Assistant Chief, a position he has held since February 2001. MCAH includes professionals from various clinical, public health, and scientific disciplines.

MCAH consists of six branches:

- Epidemiology, Assessment and Program Development
- Fiscal Management and Contract Operations
- Program Allocations, Integrity and Support
- Program Standards
- Policy Development
- California Birth Defects Monitoring Program

> Epidemiology, Assessment and Program Development (EAPD) Branch

EAPD Branch analyzes and assesses program and population-based data and information that allow MCAH to monitor program implementation, evaluate program effectiveness, develop policies, and target resources to the highest risk populations. EAPD Branch also oversees the compilation of all federal Title V reporting requirements for the annual block grant application/report and statewide five-year needs assessment.

Mike Curtis, Ph.D., is the Acting Chief of EAPD Branch, a position he held since June 2007. EAPD Branch consists of two sections with a total of 19 staff positions:
- Epidemiology, Evaluation and Data Operations
- Surveillance, Assessment and Program Development

EAPD Branch also houses the Human Stem Cell Research and Cord Blood (HSCRCB) Program, which is responsible for implementing legislation mandating the monitoring of stem cell research in California.[31]

> Fiscal Management and Contract Operations (FMCO) Branch
FMCO Branch assumes the contract monitoring functions for MCAH, including fiscal forecasting, budget-related work, management of over 400 contracts, and working with Department of Finance and other control agencies. Jo Miglas is the Chief of the FMCO Branch, a position she's held since 2007.

FMCO Branch consists of three units with a total of 23 staff positions:
- Accounting and Business Operations
- Maternal, Child and Adolescent Health Contracts and Grants.
- Office of Family Planning Allocation and Matched Funding

> Program Allocation, Integrity and Support (PAIS) Branch
PAIS Branch undertakes activities associated with allocation and matched funding of MCAH programs; program integrity; special projects and administrative activities associated with more than fifteen MCAH programs, including bill analysis and regulation development; policies and procedure development; administrative activities related to management analysis, personnel, training, and procurement; and information technology management, including website maintenance, local area network support, and management of servers, hardware, software, and inventory. Fred Chow is the Chief of the PAIS Branch, a position he has held since 2007.

PAIS Branch consists of three units with a total of 18 positions:
- Allocation and Matched Funding
- Special Projects and Administrative Support Unit
- Information Technology Unit

> Program Standards Branch (PS)
The Program Standards Branch coordinates the implementation of standards of care for pregnant women, children, and infants in the AFLP, Advanced Practice Nursing program, BIH, CPSP, and local MCAH programs. PS program consultants provide consultation and technical assistance to LHJs and other organizations. Anita Mitchell, MD is the Chief of PS Branch, a position she has held since July 2005. Dr. Mitchell is board certified in Pediatrics. The PS Branch consists of a total of 11 staff positions.

> Policy Development (PD) Branch
PD Branch develops the policy and procedures in support of all MCAH programs and collaborates on Federal, State, and local levels, providing expertise on multiple health priorities including nutrition, obesity, breastfeeding, physical activity, oral health, the StateECCS, preconception health, FIMR, SIDS, RPPC, CPeTS, CDAPP, CMQCC, CPQCC and BIH program development. PD Branch identifies relevant data points for annual reporting to ensure that LHJs address state priorities and program requirements.

Karen Ramstrom, DO, MSPH, is the Chief of PD Branch, a position she has held since May 2006. Dr. Ramstrom is board-certified in Preventive Medicine and Family Medicine. PD Branch consists of eleven staff positions.

> California Birth Defects Monitoring Program (CBDMP)
CBDMP is legislatively mandated to provide surveillance of birth defects and maintains a birth defect registry. CBDMP joined MCAH in January 2007.32 Marcia Ehinger, MD, board-certified in pediatrics and clinical genetics, is the Chief of CBDMP, a position she has held since July 2007.

An attachment is included in this section.

An attachment is included in this section.

D. Other MCH Capacity

Information about the MCAH Program is provided in Section III C (Organizational Structure) above. Information about the CMS Branch is provided below.

The CCS program is authorized by the Health and Safety Code Division 106, Part 2, Chapter 3, Article 5, Sections 123800-123995. GHPP, which provides services to individuals with certain genetic conditions, is authorized by the Health and Safety Code Division 106, Part 5, Chapter 2, Article 1, Sections 125125-125191. The CHDP program, California's preventive healthcare program for children, is authorized by the Health and Safety Code Division 106, Part 2, Chapter 3, Article 6, Sections 124025-124110 and by Division 103, Part 3, Chapter 1, Article 1, Section 104395. NHSP is authorized by the Health and Safety Code Division 106, Part 2, Chapter 3, Article 5, Section 123975 and Article 6.5 (commencing with Section 124115).

Luis Rico, Chief, Systems of Care Division is Acting Chief for the CMS Branch until a replacement can be recruited for the position. The CMS Branch was reorganized in 2005. The Branch is composed of the following five sections: Program Development, Regional Operations, Statewide Programs, Program Support, and Information Technology.

> Program Development Section (PDS)
PDS is responsible for the development and implementation of program policy, regulations, and procedures for the programs administered by the Branch and for provision of statewide consultation in a variety of professional health disciplines. Jill M Abramson MD, MPH is the Chief of the Program Development Section. She is a board certified pediatrician and is board eligible in Preventive Medicine. PDS has 15 positions.

The PDS Section consists of three units: the Program Policy and Analysis Unit, the Research Unit and the State Consultation Unit. The Program Policy and Analysis Unit is responsible for development and implementation of program policy, regulations, and procedures for all programs administered by the Branch. Unit staff develop provider standards for CCS; develop policies and procedures to assist in the implementation of HRIF and Pediatric Palliative Care programs; review and approve/deny all requests for organ transplants for children covered by CCS and Medi-Cal; and provide pediatric consultation to Medi-Cal and other DHCS programs. The unit is also responsible for research and program analysis functions and development and implementation of a pharmaceutical rebate program for CCS and GHPP, and implementation of a new delivery system that enhanced access to medical foods and improved clinical management for metabolic patients.

The Research Unit consists of three research staff responsible for program data retrieval, aggregation and analysis for the CCS and CHDP programs. The Statewide Consultation Unit staff provide technical assistance in the disciplines of medicine, nursing, social work, nutrition, dentistry, dental hygiene, and physical therapy and participate in the evaluation and monitoring of

county CCS and local CHDP programs for compliance with federal and state regulations and local policies and procedures. Staff in the unit are also responsible for ensuring that all providers who deliver services to children are qualified and in good standing with the appropriate board under the Department of Consumer Affairs and for assisting with on-site reviews of hospitals, special care centers, neonatal and pediatric intensive care units, and medical therapy units for compliance with established program standards, policies, and procedures.

> Regional Operations Section (ROS)
ROS is composed of three CMS regional offices located in Sacramento, San Francisco, and L.A.. The section provides case management services for CCS-eligible clients residing in dependent counties (those with populations of less than 200,000). Case management services include, but are not limited to, determination of medical eligibility and authorizations for services, including review and approval of EPSDT Supplemental Services requests, resolution of financial appeals, determination of eligibility for MTU services, and program consultation/technical assistance.

Regional office professional staff also have oversight responsibilities for local CCS and CHDP programs, including evaluating and monitoring county CCS and local CHDP programs for compliance with federal and State regulations and local policies and procedures. Oversight responsibilities include, but are not limited to, program development, review and approval of annual budgets and work plans, and provision of technical assistance and program consultation.

Staff in the regional offices are responsible for coordinating and facilitating on-site reviews of hospitals, special care centers, neonatal and pediatric intensive care units, and medical therapy units for compliance with established program standards, policies, and procedures and for certifying outpatient rehabilitation centers located within CCS medical therapy units.

V. David Banda is the ROS Section Chief, a position he has held since December 2008. He was manager of the CMS Hearing & Audiology Services Unit/NHSP for 10 years and has more than 30 years of experience in the Department. In 2009, the Governor's budget eliminated 12 positions. ROS now has 40 positions.

> Statewide Programs Section (SPS)
The Statewide Programs Section is responsible for administration of specialty programs with statewide responsibilities. Joleen Heider-Freeman is the Section Chief of SPS as of May 2005. The SPS currently has 24 filled positions. The SPS vacant positions have been cut due to the Governor's Balanced Budget Reduction Act.

There are three units within the section: Specialty Programs, Hearing and Audiology Services, and GHPP. The Specialty Programs Unit is responsible for the monitoring of the HCPFC, identifying Child Health and Disability Prevention (CHDP) program administrative needs and priorities and initiates efforts to accomplish CHDP objectives, and offers technical assistance with the Transition Planning Statewide Guidelines.

The Hearing and Audiology Services Unit is responsible for the maintenance and monitoring of NHSP and for providing consultation/technical assistance to providers and local programs regarding program benefits. The Unit is also responsible for the development and implementation of the NHSP Data Management Service. Staff in the unit monitor contracts with NHSP Hearing Coordination Centers providing follow-up testing and treatment services to infants with suspected hearing loss; evaluate and certify school audiometrists; and provide technical assistance for the CHDP providers on the audiometric testing of hearing for children in the school setting.

The Hearing and Audiology Services Unit develops and implements NHSP and CCS policy relating to hearing services. Monitoring and quality assurance activities are conducted with NHSP contractors and CCS providers. GHPP provides all medical and administrative case management services for approximately 1750 clients statewide with serious, often life threatening, genetic conditions (e.g., hemophilia, cystic fibrosis, sickle cell anemia).

> Program Support Section (PSS)
PSS is composed of three units and has responsibility for a variety of activities in support of Branch operations. The Section Chief is Erin M. Whitsell. She has held the position since 2003. There are currently 17 positions in PSS.

The Administration Unit is responsible for fiscal, personnel, contracting, purchasing and business services for CMS. Staff in the unit review, approve, and process CCS county and CHDP county/city invoices; resolve invoicing/payment issues; develop and implement administrative and fiscal procedures for new programs administered by the Branch; develop and manage contracts and interagency agreements; process contract and county expenditure invoices; and maintain personnel and business services transactions for all CMS Branch staff.

The Provider Services Unit (PSU) is responsible for enrolling providers for the CCS, CHDP, and GHPP programs and acts as a liaison between CMS Branch programs, their providers, the Medi-Cal Payment Systems Division, and the State fiscal intermediary. Staff in PSU also process hospital approval updates and all special care center directory updates and works with Information Technology staff in posting updates to various sites. Staff also develop and conduct provider training to individual and group health care providers, hospitals, special care centers, clinics, etc. in statewide formal training seminars.

The Clerical Support Unit provides general clerical support to the CMS Branch management and staff. The unit is responsible for completion of complex typing assignments; assisting in organizing and filing all program documents; respond to telephone calls, faxes, and e-mails; disseminates program information to State staff, local agencies, the general public, and various other organizations; coordinates meetings; and, makes travel arrangements for staff.

> Information Technology Section (ITS)
ITS is responsible for all aspects of information technology support for the CMS Branch and CMS Net, the Branch's automated case management system. This includes CMS Branch office products, CMS Net network support, CMS Net operations, and CMS Net Help Desk operation. The section provides consultation to the State Health and Human Services Agency Data Center regarding county LAN/WAN connectivity and is responsible for corrections and modifications to CMS Net application. Brian Kentera was appointed Chief in February 2008. The CMS Net system is used by the county and State Regional CCS offices to manage the health care of approximately 170,000 children.

The section is divided into two units: Information Systems and Information Technology. This section provides consultation to Office of Technology Services (or OTech), a division within the Office of the State Chief Information Officer, formerly the California Department of Technology Services. ITS currently consists of 11 State staff and 9 contractors.

An attachment is included in this section.

An attachment is included in this section.

E. State Agency Coordination

MCAH and CMS are the primary entities in California that provide core public health and essential health care services for mothers, infants, children and CSCHN through its Title V programs. This requires involvement at the community, local and state level and seeking out of community based organizations, building intra and inter-agency collaboration, partnering with universities, health foundations, hospitals and health professional organizations and working with individuals we serve. Both MCAH and CMS provide leadership in working with these various stakeholders to identify and focus our priorities, establish a process and create a plan to address these priorities and demonstrate progress in meeting these priorities.

Both MCAH and CMS actively foster statewide collaboratives and partnerships. A detailed discussion of our major collaboratives and partnerships was included in Section III-B, Agency Capacity.

> Department of Education (CDE)
MCAH collaborates with CDE on the ECCS grant to coordinate early childhood health programs for California's children.

CMS and CDE work collaboratively to assure all infants with hearing loss identified through the NHSP are referred to Early Start. The MCHB grant supports improvement of services for early identification and intervention of hearing loss.

The CCS MTP provides physical therapy and occupational therapy services to program eligible children in the public school setting. The local education agency provides the space and equipment for the MTU, and the county CCS program provides the administrative and clinical staff.

The CMS Liaison to CDE participates on the Improving Special Education Services Stakeholders Group to achieve objectives of the State Improvement Grant.

MCAH is a part of the ASHWG collaborative comprised of representatives from CDPH, CDE and non-governmental organizations to address sexual and reproductive health issues of California adolescents.

MCAH collaborates with CDE on the ECCS grant to coordinate early childhood health programs for California's children. In addition, The ECCS Coordinator is working with CDE on two early childhood grants: 1) to train early childhood child care and educators on evidence-based practices for identifying and working with autistic children in their environments, and 2) to train the trainers at pilot sites to work with early childhood care and education staff on how to promote the social emotional wellness of young children. The goal is to create a statewide, sustainable system that is based on a common approach developed by Vanderbilt University Center on the Social Emotional Foundations for Early Learning.

> Department of Developmental Services (DDS)
CCS and Medi-Cal provide medical services to eligible infants and toddlers receiving services through the Early Start Program. Through participation on the Interagency Coordinating Council and Health Services Committee, CMS maintains ongoing communication with DDS. Some CCS clients also receive Regional Center Services and care coordination between CCS and DDS.

CMS executed a Data Use Agreement with DDS to obtain outcome data on Early Start program enrollment of infants identified with hearing loss through the Newborn Hearing Screening Program.

MCAH collaborates with the Early Start program at DDS on planning and implementation activities of the ECCS grant. The ECCS coordinator has been appointed by Dr. Mark Horton, to represent CDPH on the DDS Early Start Interagency Coordinating Council, as mandated by the Individuals with Disabilities Education Act. CDPH also participates on the Data Committee.

DDS has expressed interest in the potential for prevention through MCAH preconception health activities and invited to participate on the PCHC.

> Department of Social Services (DSS)/Children in Foster Care

The Health Care Program for Children in Foster Care (HCPCFC) is a collaboration between DSS and CMS to improve oversight of health care for children in foster care. CMS initiated a performance measure to evaluate the effectiveness of the HCPCFC administrative case management. A data collection system is being developed.

With the passage of AB X4 4 in July of 2009, the HCPCFC became a mandated program statewide. The role of the Public Health Nurse (PHN) remains that of administrative case manager working collaboratively with the Social Worker and/or Probation Officer.

Five regional committees as well as a statewide subcommittee of the CHDP Program Executive Committee meet on a quarterly basis.

AFLP continues to collaborate with the DSS/CalLearn as part of case management oversight for pregnant and parenting teens.

Under the ECCS grant, the Statewide Screening Collaborative (SSC) continues to provide technical assistance to DSS to implement developmental screening at the county level for foster children as part of the federal law, Child Abuse Prevention and Treatment Act, which requires that any child under the age of 2 with substantiated abuse or neglect be referred to early intervention services.

> Managed Risk Medical Insurance Board (MRMIB)

CMS and MRMIB coordinate quarterly meetings throughout the state for medical plans, and separate meetings for dental plans. Ad hoc subcommittees comprised of members from CCS and MRMIB work together to train providers and resolve program issues.

Under ECCS grant, the SCC is working with MRMIB to identify ways to incentivize the use of standardized developmental screening tools in their plans. A survey was conducted in 2009 that showed only 1.26% of their children under the age of 5 was being screened with a validated tool.

> Childhood Lead Poisoning Prevention Branch (CLPP)

CMS, through CHDP, provides lead screenings for children. The CCS program covers the cost of evaluation and treatment of serious lead poisoning cases. The CHDP program and CLPP developed new approaches to screening that consider all low income children to be at risk and require blood lead screening.

The Health Assessment Guidelines section on management of elevated blood lead levels has been revised as recommended in the November 2007 Morbidity and Mortality Weekly Report.

CHDP and CLPP released a joint letter in December 2008 outlining the updated CDC recommendations on childhood lead poisoning prevention.

MCAH and CMS participate in the statewide planning process led by CLPP to eliminate childhood lead poisoning and meet the HP 2010 goal. A federal interagency strategy and objectives have been developed.

> Immunization Branch (IZ)

The CMS and IZ Branches collaborate with the Vaccines for Children (VFC) program by providing vaccination coverage and modifications through the CHDP program, including: tetanus, diphtheria and acellular pertussis vaccine; FluMist; meningococcal conjugate; measles, mumps, rubella, and varicella; hepatitis A, hepatitis B, Haemophilus influenzae type B vaccine, rotavirus, influenza, human papillomavirus and meningitis vaccines.

CMS and IZ Branches, Medi-Cal, and MediCal Managed Care (MCMC) meet three times per year to discuss results of the Advisory Committee on Immunization Practices (ACIP)-VFC National Meetings. CMS and IZ branches work together on adding new vaccines and modifying existing vaccine benefits in concordance with the ACIP recommendations.

MCAH has partnered with the IZ Branch to provide immunization update to the MCAH Perinatal Services coordinators, review immunization brochures on immunization during pregnancy, development of educational materials on H1N1 in pregnancy and the importance of influenza vaccination.

> California Nutrition, Physical Activity and Obesity Prevention Program/ Champions for Change
MCAH and CMS collaborate with the California Nutrition, Physical Activity and Obesity Prevention Program and the Champions for Change to promote healthy lifestyles to reduce the prevalence of obesity. MCAH and CMS participated on the 2009 Childhood Obesity Conference committee, which showcased evidence-based prevention interventions and community efforts. MCAH featured their Birth and Beyond California (BBC) project, working with hospitals to integrate Quality Improvement efforts within the maternity care setting to ensure policies and practices are supportive of breastfeeding, as well as the work they are doing to promote healthy weight before, during and after pregnancy, and "Tracking Childhood Obesity Trends Using Geographic Information System (GIS) Mapping, California: 1996-2006." MCAH was also on the planning committee for the 2009 Weight of the Nation, a national forum to highlight progress in the prevention and control of obesity through policy and environmental strategies. MCAH was instrumental in including a life course perspective and a presentation on BBC.

> Medi-Cal Managed Care Division (MCMC)
California WIC Association, WIC, and MCAH meet monthly with Medi-Cal to clarify and simplify access to breastfeeding supportive Medi-Cal benefits.

> Safe and Active Communities Branch (SAC)
The Safe and Active Communities (SAC) Branch is the lead agency within CDPH responsible for coordinating statewide injury and violence prevention efforts. This includes the prevention of intentional and unintentional injuries as well as surveillance and epidemiology. Current intervention efforts focus on child passenger safety, violence prevention (ranging from child maltreatment, violence against women, including sexual assaults, homicide and suicide), elder maltreatment, fall prevention, pedestrian safety and creating safe and active communities conducive to walking and bicycling. SAC's injury surveillance and epidemiology program includes the Calfornia Injury Data Online, a web-based do-it-yourself injury surveillance table builder (www.dhs.ca.gov/EPICenter).

MCAH collaborates with SAC on injury prevention activities, including local training programs, SIDS and the Child Death Review Team (CDRT), SAFE-KIDS California Advisory Committee and the Strategic Coalition on Traffic Safety. MCAH Title V support data collection and prevention work of the local child death review teams. MCAH and SAC are also working together to address Electronic Death Recording System data issues related to Shaken Baby Syndrome and SIDS.

> Office of Audits and Investigations
MCAH works closely with DHCS Audits and Investigations to ensure the integrity of MCAH programs.

> Genetic Disease Screening Program (GDSP)
CMS and GDSP work together to address issues as they arise and update policies and reporting

/forms as needed in an effort to ensure that babies who screen positive receive expedited care at a CCS approved Special Care Center. Although CCS makes a special effort to expedite these cases some slight delays may occur due to the CCS staffing cuts.

CCS provides services for conditions identified on newborn screening tests, develops standards, and approves Metabolic, Endocrine, and Sickle Cell Special Care Centers (SCCs) for treatment.

> Women, Infants & Children (WIC) Supplemental Nutrition Division
MCAH and CMS collaborate with WIC in a variety of areas, including improvement of prenatal care, linkages between MCAH and WIC data files, obesity prevention, oral health, childhood injury prevention, and breastfeeding. In 2010, MCAH began collaborating with WIC on several applied, public health research projects (as described in Section III-A).

MCAH collaborated with WIC on updating WIC food packages to ensure foods address the nutritional needs of women, infants and children and are consistent with the 2005 Dietary Guidelines for Americans. The modifications enhance the nutritional quality of foods available to WIC families, improve health outcomes, and expand the cultural food options and overall food choices for WIC's diverse populations. CMS also collaborated on the regulations for medical providers. MCAH partnered with WIC to facilitate diffusion of the new information.

WIC, MCAH, California WIC Association, and the Nutrition, Physical Activity and Obesity Prevention Program developed a California Breastfeeding Roundtable to develop and implement a breastfeeding strategic plan.

CMS collaborates with WIC regarding CHDP provider relations, relevant health assessment guidelines and communications. For example, WIC's food package changes and the new pediatric referral form were communicated to CHDP providers via Provider Information Notices. CHDP Health Assessment Guidelines promote the use of WIC nutrition education materials for providers to use for anticipatory guidance. Additionally, CMS assists WIC with using the Pediatric Nutrition Surveillance System (PedNSS) prevalence data for local program nutrition education plans.

CMS also coordinates with WIC regarding the provision of specialty enteral nutrition products for the Special Needs Population in WIC and CCS.

CMS, WIC and MCAH meet quarterly for program updates.

> Universities
MCAH and CMS work closely with the University of California and other universities in the state. Partnerships include the National Adolescent Health Information Center and the Bixby Center for Reproductive Health Research & Policy at UCSF, Stanford University (on CMQCC and CPQCC issues), and the Center for Injury Prevention Policy and Practice at San Diego State University (SDSU). UCSF FHOP provides consultation and training to local MCAH jurisdictions in monitoring and updating local 5-year plans, data collection, identification of data sources, data analysis and survey development. FHOP also provides consultation, data analysis, stakeholder meetings and interviews for the Title V Needs Assessment. In collaboration with MCAH, UCSF Center on Social Disparities in Health conducts, analyzes, and reports on MIHA.

UCLA's Center for Healthy Children, Families and Communities participates in the Statewide Screening Collaborative as well as collaborate with the maternal QI project..

MCAH provides MPH student internships, and mentoring for students and physicians in training.

MCAH contracted with the UCSF Center on Social Disparities in Health to assess BIH program services. UCSF's recommendations have served as a foundation to develop a standardized

intervention and evaluation plan.

Through a contract with SDSU Institute of Public Health and CCHA the Catheter Associated Bloodstream Infection (CABSI) Prevention Neonatal Quality Improvement Initiative (NQI) using the IHI model was initiated in 2007 with 13 regional NICUs. CABSIs were reduced by 29% in all weight groups. The collaborative expanded in 2008 to include all 22 CCS-approved regional NICUs. And in July 2009, the collaborative has continued on with 14 regional NICUs and expansion to all hospital associated bloodstream infections.

> California District of the American Academy of Pediatrics (AAP-CA)
Under the leadership of MCAH ECCS, the SSC is working with the AAP-CA. AAP-CA has designated Dr. Renee Wachtel, a developmental pediatrician, to represent the AAP-CA on the SSC. She has been leading a subcommittee for the Collaborative to work with Medi-Cal Fee-For-Service on identifying issues with developmental screening reimbursement. Recommendations to be provided to Medi-Cal in spring 2010.

Quarterly conference calls between the AAP-CA Chapter Champions and the state NHSP staff continue. Three of the four Chapter Champions participated in the national Early Hearing Detection and Intervention meeting in 2010. One continues to be an active participant in the NHSP quality improvement learning collaborative.

The CMS Branch collaborates with AAP-CA on many initiatives such as the 1115 Waiver, the CCS Needs Assessment, and the Palliative care Initiative.

> California Association of Neonatologists (CAN) and Stanford University
CMS and MCAH work with these groups on a perinatal and neonatal morbidity and mortality reporting system that provides information on quality of care, and serves as a basis for quality improvement in participating hospitals. CMS participates in CAN/District IX Board Meetings and annual conferences and in 2009-10 has provided progress reports on the Federal 1115 Waiver Renewal and the CCS Technical Workgroup which will be making recommendations for CCS redesign http://www.dhcs.ca.gov/provgovpart/Pages/WaiverRenewal.aspx. Collaboration with Stanford and CPQCC continues with NICU and HRIF data collection and the breast milk nutrition QI Collaborative. CMS has worked with the Packard Foundation as they assess a service system for Children and Youth with Special Health Care Needs (CYSHCN) in CA.

> Children's Specialty Care Coalition (CSCC)
CSCC is an organization of pediatric specialty and subspecialty providers practicing at CCS-approved tertiary hospitals and SCCs. CSCC has participated in the Title V Needs Assessment process and is also an active participant in the 1115 Waiver Redesign process.

> California Conference of Local Health Officers (CCLHO)
CMS works with CCLHO on issues related to county program operations for CSHCN, preventive health services for children, and the CMS Net Data system.

> California Children's Hospital Association (CCHA)
The Children's Hospitals are vital providers of services to children in the CCS program. CMS works closely with hospitals in the Title V Strategic Planning Process; develops quality improvement initiatives; and advocates for children's services.

In collaboration with CCHA, CMS is sponsoring a Neonatal Quality Improvement Initiative. CMS collaborates with CCHA in the NQI Initiative, which includes all 22 Regional NICUs.

> Other Professional Organizations

CMS collaborates with the California Dental Association, the California Association of Orthodontists, the Oral Health Access Council, the California Orthopedic Surgeons Association, the California Association of Home Health Agencies, California Association of Ophthalmologists, California Association of Medical Products Suppliers and the Hemophilia Council and Foundations to improve working relationships, recruit providers, and address barriers to access to services. CMS works with Medi-Cal to improve reimburse processes for providers.

A number of professional organizations are actively involved in the Title V Needs Assessment process and participating in the 1115 Waiver Redesign process.

CMS collaborates with the Children's Hospice and Palliative Care Coalition to develop a federal Medicaid waiver to allow CCS clients to access 'hospice-like' services while still receiving treatment services for their eligible conditions. There are 60 members of the stakeholder group providing input into the waiver design and development, including representatives from the Children's' Hospitals, University of California hospitals, CSCC, hospices and home health agencies.

The Palliative Care Waiver was approved by Federal Centers for Medicare and Medicaid Services with a start date of July 1, 2009.

ECCS partners with many others through the SSC, including First 5, the California Academy of Family Physicians, the California Association of Health Plans, and the Advancement Project.

MCAH contracts with the California Adolescent Health Collaborative (CAHC) to support local health jurisdictions' efforts on adolescent health.

MCAH collaborated with the Network for a Healthy California to develop a proposal for a preconception health social marketing campaign, funded by a HRSA/MCHB First Time Motherhood grant.

MCAH and CMS are involved in strategic planning for California's CDC-five year funded Nutrition, Physical Activity and Obesity Prevention Program. CMS conducted statewide webinars with local CHDP program staff to identify health care strategies for the health care sector of the Obesity Prevention Plan.

CMS coordinated with Medi-Cal Managed Care Health Plans: Kaiser, Cal Optima, Anthem Blue Cross and Health Plan of San Joaquin to provide training workshops, "Pediatric Obesity: Provider Skill Sets for Improved Care" to accelerate provider practice changes regarding childhood obesity. CMS is collaborating with Head Start on childhood obesity intervention since the majority of Head Start children receive health assessments through CHDP.

F. Health Systems Capacity Indicators

Introduction

This section covers the following Health Systems Capacity Indicators for California:

1) Rate of asthma hospitalizations among children (age < 5 years);
2) Percent of Medicaid enrolled children (age < one year) who received at least one EPSDT health assessment;
3) Percent of State Children's Health Insurance Program (SCHIP) enrolled children (age < one year) who received at least one EPSDT health assessment;
4) Percent of women (age 15-44) with a live birth whose observed to expected prenatal visits were greater than or equal to 80 percent on the Kotelchuck Index;

5) Comparison of health system capacity indicators for Medicaid and non-Medicaid populations;
6) Percent of poverty for eligibility in Medicaid and SCHIP Programs for infants, children, and pregnant women;
7) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program, and Percent of EPSDT eligible children (age 6-9 years) who received any dental services;
8) Percent of SSI beneficiaries (age < 16 years) who received rehabilitative services from the State CSHCN Program; and
9) Data capacity, including general MCH data capacity and capacity for monitoring adolescent tobacco use.

Please note that in California, the Medicaid Program is called Medi-Cal; SCHIP is called HF; EPSDT is called the CHDP Program.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	24.6	24.3	22.8	22.0	22
Numerator	6458	6559	6186	5993	
Denominator	2630401	2698813	2710425	2723382	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
A manual indicator is reported for 2009 based on 2008.

Notes - 2008
Numerator: State of California, Office of Statewide Health Planning and Development, Patient Discharge Data (OSHPD-PDD), January 1-December 31, 2008. Primary diagnoses of each discharge abstract were tabulated, secondary diagnoses were not included. Denominator: Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007. Tabulations (by place of residence) were done by the MCAH Program.

Data for 2006-2008 should be not compared to data reported in previous years due to updates in the 2000-2050 population projections released by the California Department of Finance (July 2007). Rates for prior years using these updated population estimates: 2000 = 35.1; 2001 = 32.8; 2002 = 33.6; 2003 = 31.6; 2004 = 29.6; 2005 = 23.9

Notes - 2007
Numerator: State of California, Office of Statewide Health Planning and Development, Patient Discharge Data (OSHPD-PDD), January 1-December 31, 2007. Primary diagnoses of each discharge abstract were tabulated, secondary diagnoses were not included. Denominator: Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007. Tabulations (by place of residence) were done by the MCAH Program.

Data for 2006-2007 should be not compared to data reported in previous years due to recent updates in the 2000-2050 population projections released by the California Department of Finance (July 2007). Rates for prior years using these updated population estimates: 2000 = 35.1; 2001 = 32.8; 2002 = 33.6; 2003 = 31.6; 2004 = 29.6; 2005 = 23.9

Narrative:
HSCI 01 is the rate per 10,000 for asthma hospitalizations among children less than five years old. The child asthma hospitalization rate continues its decline and is at a new low of 22 per 100,000 in 2008. Nationally, asthma prevalence increased between 1980 and 2002 for children and adults.[33] Since 2005, California has consistently achieved the Healthy People 2010 objective of 25 hospitalizations per 10,000 children under age 5.

Efforts to address childhood asthma are guided by the California Asthma Public Health Initiative (CAPHI), which is implemented by the Center for Chronic Disease Prevention and Health Promotion in CDPH. CAPHI seeks to reduce preventable asthma morbidity and mortality; to eliminate disparities in asthma practices and outcomes; and to implement effective programs and policies in asthma education, management, and prevention according to the National Asthma Education and Prevention Program Guidelines.

CAPHI developed the Strategic Plan for Asthma in California for 2008-2012. This plan involved collaboration and input from asthma experts, agency partners, and stakeholders from CDPH, DHCS, Emergency Medical Services Authority, CDE, DSS, Environmental Protection Agency, Air Resources Board, and the Occupational Safety and Health Administration. The plan highlights five priorities: eliminating asthma disparities; providing education and awareness; focusing on asthma across the lifespan; creating institutional and systems change; and promoting effective policies.

CAPHI is working with three Central Valley LHJs to strategically and collaboratively reduce the local asthma burden through a collaborative process involving local community asthma stakeholders. Local collaboratives completed CAPHI's Comprehensive County Asthma Assessment (CCAA) tool that addresses asthma-related assets, challenges, and opportunities to reduce the local burden of asthma. This process supports the development of a prioritized work plan for implementing ten objectives based on the findings from the CCAA. The work plan will be implemented and evaluated in the final two years of the program, concluding in 2011.

A Summit is being convened on June 29, 2010 to highlight clinical best practices and effective models for providing quality asthma care and improving health outcomes for those affected by asthma.

CAPHI hosts an online library of asthma educational resources for the public and a free CME asthma quality improvement training series for providers at http://www.betterasthmacare.org.

CAPHI participate in the development and promotion of school asthma resources, including Guidelines for Managing Asthma in California Schools and the Asthma Action Plans for Schools and Families. CAPHI is currently partnering with the American Lung Association of California and other stakeholders on the development of the first state strategic plan for chronic obstructive pulmonary disease.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	73.7	71.3	82.5	83.4	83.4
Numerator	455151	460738	580680	552084	
Denominator	617571	646633	703949	661753	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Manual indicator for 2009 is based on 2008. 2009 data will be available in March 2011.

Notes - 2008
This measure is the percent of Medi-Cal enrolled children less than one year of age who received at least one CHDP service in the reporting year.
Source is CHDP program data and State Medi-Cal claims files.
Numerator is the number of children under one year of age enrolled in Medi-Cal who received at least one CHDP service in FY 2007 -2008
Denominator is the unduplicated number of children under one year of age enrolled in Medi-Cal in FY 2007-2008.

Notes - 2007
This measure is the percent of Medi-Cal enrolled children less than one year of age who received at least one CHDP service in the reporting year.
Source is CHDP program data and State Medi-Cal claims files.
Numerator is the number of children under one year of age enrolled in Medi-Cal who received at least one CHDP service in FY 2006 -2007
Denominator is the unduplicated number of children under one year of age enrolled in Medi-Cal in FY 2006-2007.

Narrative:
Health Systems Capacity Indicator 02 (HSCI-02) is the percent of Medi-Cal enrolled children less than one year of age who received at least one CHDP health assessment in the reporting year. In FY 2008-09, HSCI 02 was 83.4 percent, an increase of .9 % from FY 2006-07. The denominator--unduplicated Medi-Cal enrolled children less that one year of age (661,753 for FY 2008-09)--has decreased by 5.99% since 2006-07. The continued increase in this indicator is most likely due to CHDP Gateway pre-enrollment and infant deeming.

The Memoranda of Understanding between MCMC plans and local CHDP programs continue. Each local CHDP program coordinates with MCMC plans to develop a procedure for working together. DHCS provides technical assistance and program consultation to local CHDP programs and MCMC plans to resolve problem areas. The CHDP program at the local level provides outreach to providers and children and their families (such as health fairs and other community events). The CMS Branch collaborated with the California Medical Home Project and the LA Medical Home Project. LA County CCS also works with LA Care MCMC Plan for better coordination of care by the medical home.

Quarterly meetings between CHDP programs and MCMC plans are occurring in some counties and less frequently in other counties. The CMS Branch continues to collaborate with MCMC plans on statewide operational problems that occur with the carve-out of CCS services in Medi-Cal and HF managed care plans.

Local CHDP programs continue to provide education, training and outreach to CHDP provider office staff and the community in order to assist the number of eligible children into health care. The CHDP Gateway pre-enrollment process and infant deeming appear to be having the greatest effect on this performance measure.

California has made a strong commitment to reducing the number of uninsured children and ensuring access to healthcare services for children. MCAH Division programs, such as the AFLP, BIH and CPSP screen and assess children and adolescents for Medi-Cal eligibility and assist them in obtaining services.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	0.0	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	1	1	1	1	1
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data is not availble for analysis.

Notes - 2008
Data is not availble for analysis.

Notes - 2007
Data is not availble for analysis.

Narrative:
Health Systems Capacity Indicator 03 (HSCI-3) is the percent of HF enrollees under one year of age who received at least one CHDP health assessment. HF plans do not conduct CHDP health assessments, but instead perform preventive examinations based on the AAP guidelines. The HF Program relies on the Health Plan Employer Data and Information Set to evaluate the performance of the health plans. These data are not available.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	78.4	78.7	78.6	79.0	79
Numerator	422294	434411	427600	416314	
Denominator	538752	552317	544255	527150	
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
A manual indicator is reported for 2009 based on 2008.

Notes - 2008
Source: State of California, Department of Public Health, Center for Health Statistics, 2008 California Birth Statistical Master File.

Tabulations (by place of residence) were done by the MCAH Program. Observations with missing values were subtracted from the denominator when calculating the percents shown.

Notes - 2007
Source: State of California, Department of Public Health, Center for Health Statistics, 2007 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program. Observations with missing values were subtracted from the denominator when calculating the percents shown.

Narrative:
Health Systems Capacity Indicator 04 (HSCI-4) is the percent of women ages 15 to 44 with a live birth during the year whose observed to expected prenatal visits are at least 80 percent on the Kotelchuck Index. This index considers the mother's timing of initiation of prenatal care and the number of prenatal care visits recommended by ACOG.

The rate for HSCI 04 has steadily increased to 79% in 2008. Asians have the highest rate at 82.7% followed by Whites (82.4 %), Hispanics (77.1%), Multi-Race (76.1%), African-American (74.8%), and American-Indians (66.0%).Pacific Islanders have the lowest rate at 65.1%.

LHJs perform outreach, client education and case-finding functions, including a toll-free telephone information service and targeted activities designed to assist women in receiving early and continuous prenatal care. Programs also provide critical social support services, case management and client follow-up.

Local AFLP use marketing, home visitation, and follow-up with pregnant women to educate clients and stakeholders on the importance of prenatal care. Regional AFLP representatives meet to discuss strategies for improving prenatal care utilization.

BIH provide health education, health fairs, provider coordination, media campaigns and outreach to increase community awareness of the importance of prenatal care. Some programs provide transportation to prenatal visits. A new intervention to be piloted in July 2010 ensures that BIH provide standardized services and includes an evaluation component to assess its effectiveness in meeting program goals.

CPSP provides support to Medi-Cal providers in offering comprehensive prenatal care, which includes obstetrics, nutrition, health education, and psychosocial support. Prenatal care providers receive a financial incentive to initiate prenatal care in the first trimester of pregnancy.

MCAH LHJs partner with WIC to provide referrals to prenatal care when women come for WIC services. Other programs that support improvements in adequate prenatal care include the American Indian Infant Health Initiative (AIIHI) in DHCS, which provides case management

services to high-risk Indian families, and t (AIM) Program in MRMIB, which offers low-cost health care coverage for pregnant women who do not qualify for Medi-Cal.

Prenatal care is critically important for the health of the fetus and the mother and preconception and interconception care are part of a continuum of care and one that requires greater service integration. MCAH convened PHCC in 2006 to encourage providers to address risk factors before pregnancy and educate women of childbearing age about preconception health. In 2009, the PHCC launched a website that provides information for consumers and providers about health before pregnancy: (www.everywomancalifornia.org).

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	87.9	92.4	98.7	94.8	94.8
Numerator	3236633	3644145	4400662	3364542	
Denominator	3680740	3945697	4459912	3549664	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
A manual indicator is reported for 2009 based on 2008 data.

Notes - 2008
Numerator: All persons 1 to 21 years of age who received a service paid by the Medi-Cal program during the Federal fiscal year: October 2007-September 2008 (this is an unduplicated count), including both Fee-for-Service and Managed Care beneficiaries, as well as certified and uncertified beneficiaries (i.e., those who shared a cost for their care). Source: Fiscal Forecasting and Data Management Branch, California Department of Health Care Services.

Denominator: Consists of the sum of two indicators: (1) An estimate of uninsured children (1-21 years old) eligible for Medi-Cal. Source: 2007 California Health Interview Survey; (2) All persons 1 to 21 years of age who were enrolled in Medi-Cal at the end of the Federal fiscal year: September 2008 count. Source: Fiscal Forecasting and Data Management Branch, California Department of Health Care Services.

Notes - 2007
Numerator: All persons 1 to 21 years of age who received a service paid by the Medi-Cal program during the Federal fiscal year: October 2006-September 2007 (this is an unduplicated count), including both Fee-for-Service and Managed Care beneficiaries, as well as certified and uncertified beneficiaries (i.e., those who shared a cost for their care). Source: Fiscal Forecasting and Data Management Branch, California Department of Health Care Services.

Denominator: Consists of the sum of two indicators: (1) An estimate of uninsured children (1-21 years old) eligible for Medi-Cal. Source: 2007 California Health Interview Survey

http://www.chis.ucla.edu/main/DQ2/easy/output.asp; (2) All persons 1 to 21 years of age who were enrolled in Medi-Cal at the end of the Federal fiscal year: September 2007 count. Source: Fiscal Forecasting and Data Management Branch,, California Department of Health Care Services.

Note: Data prior to 2004 should not be compared because of the change in methodology beginning in 2004.

Narrative:
Health Systems Capacity Indicator 07a (HSCI-7a) is the percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program. For 2008, it is estimated at 94.8% of Medicaid eligible children received a service paid for by the Medicaid Program.

California has made a strong commitment to reducing the number of uninsured children and ensuring access to healthcare services. Activities have included:

1) Support of streamlined Medi-Cal eligibility processes that encourage continuous coverage.

2) Support for MCAH programs such as AFLP, BIH, CPSP and LHJs to screen and assess children for Medi-Cal eligibility and assist them in obtaining needed services. Several LHJs have local initiatives that assist families with uninsured children to enroll in government funded health insurance programs or pay for health insurance costs for children who are not eligible for government funded programs. The San Diego Kids Health Assurance Network Community Collaborative assisted the local Medi-Cal program in the development of educational materials to inform Medi-Cal eligible clients about the new citizenship verification requirements for Medi-Cal enrollment. Additionally, LHJs perform a wide variety of community outreach activities in multiple venues to facilitate enrollment in Medi-Cal and educate target populations about Medi-Cal services.

3) Public education media campaigns and other community education efforts to encourage eligible families to obtain medical services, such as family planning, well child care, prenatal care, childhood immunizations, and dental care.

4) Facilitation of the provision of Medi-Cal paid prenatal care services to adolescents by providing financial incentives to prenatal care providers.

5) Recruit, retain, and educate providers about the CHDP program, Gateway, and preventive services for children from families at or below 200 % of FPL. The CHDP Provider Manual is available online to assist providers with programmatic issues and day-to-day activities and provide statewide standardization of CHDP provider requirements for program participation. Local CHDP programs and their health departments assist children and their families to access preventive health examinations through health fairs, and interagency agreements with WIC and Head Start. Local CHDP staff may also participate in community Advisory Boards.

In 2007 CHDP updated their Interagency Agreement with the U.S. Department of Health and Human Services, Office of Head Start. Local CHDP programs and Head Start programs continue to collaborate regarding training on the Interagency Agreement and its impact on local programs.

The CHDP Health Assessment Guidelines for CHDP providers are under revision to include methods to provide family-centered and culturally competent care. There will be continuing CHDP collaboration with schools, Head Start and providers in order to assist more low-income children to receive periodic preventive exams.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	44.2	41.1	43.0	43.6	43.6
Numerator	353166	344152	357212	368765	
Denominator	798779	838216	830868	844898	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Manual indicator for 2009 is based on 2008. 2009 data will be available in March 2011.

Notes - 2008
This measure is the percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.
Source is the revised HCFA-416 Form, element numbers 1 and 12a.
Numerator is the revised HCFA-416 Form element number 12a for FY 2008-09.
Denominator is the revised HCFA-416 Form element number 1 for FY 2008-09.

Historical Information:
Medical Care Statistics had been providing the numerator and denominator for this performance measure until FY 2003-04 when the numerator and denominator began being provided by Medstat using the Management Information System/Decision Support System (MIS/DSS) data base. The performance measure for FY 2004-05 can be compared with FY 2003-04, but not with prior years.

Notes - 2007
This measure is the percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.
Source is the revised HCFA-416 Form, element numbers 1 and 12a.
Numerator is the revised HCFA-416 Form element number 12a for FY 2007-08.
Denominator is the revised HCFA-416 Form element number 1 for FY 2007-08.

Historical Information:
Medical Care Statistics had been providing the numerator and denominator for this performance measure until FY 2003-04 when the numerator and denominator began being provided by Medstat using the Management Information System/Decision Support System (MIS/DSS) data base. The performance measure for FY 2004-05 can be compared with FY 2003-04, but not with prior years.

Narrative:
Health Systems Capacity Indicator 07b (HSCI-7b) is the percent of EPSDT eligible children (CHDP in California) aged 6 through 9 years who received any dental services during the year. The goal of this indicator is to increase dental health services to Medi-Cal eligible children at an important stage of dental development.

In FY 2007-08, HSCI-7B was 43%, a 4.6% increase from the prior year but a 2.7% decrease from

FY 2005-06. Beginning in FY 2003-04, the numerator and denominator for this measure have been provided by Medstat using the MIS/Decision Support System database.

Current activities related to this indicator include: The CHDP Gateway covers dental services for pre-enrolled children up to 60 days after a CHDP health assessment and has increased access to dental services. CHDP Gateway offers the opportunity to apply for permanent enrollment in Medi-Cal or HF which includes dental benefits. Most Denti-Cal providers accept the pre-enrollment receipts and many children receive dental services through the Gateway.

CHDP tools such as the revised two-sided full color "PM 160 Dental Guide" will continue to improve the quality of dental screenings and more acceptable annual referrals to a dentist beginning at age one. A provider notice, under development, will encourage CHDP providers to discuss the importance of dental sealants with families of 6 and 12 year old children. Fluoride varnish applications (3/year) became a benefit of the Medi-Cal program. CHDP providers were informed of this benefit, asked to apply fluoride varnish, and be reimbursed through Medi-Cal.

Brochures entitled, "Fluoride Varnish-- Helping Smiles Stay Strong" and "Every Child Needs a Dental Home" have been released to local CHDP programs. These can be downloaded from local CHDP websites. They are currently available in three languages with three more languages planned. A resource guide has been developed and distributed to local programs. It includes online links for brochures including most oral health topics for children ages 6 through 20. There is also work on completing online links for ages 0 through 5. A Power Point training is being developed for CHDP Providers and local program staff which includes resources and oral health topics specific to screening and referring children to a dentist by age one. This training is expected to be placed on the CMS website.

The State Dental Hygienist Consultant in conjunction with the Dental Subcommittee of the CHDP Executive Committee continues dental updates to providers, local program staff, and families. The dental sections of the Health Assessment Guidelines, including anticipatory guidance, are being aligned with Bright Futures Oral Health. Changes specific to California are being added.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	8.7	32.5	31.1	28.2	30.1
Numerator	7318	27623	27058	25554	28253
Denominator	84235	85106	86914	90464	93899
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009

This measure is the percent of SSI beneficiaries through age 15 years receiving rehabilitative services through the CCS program. Source of data for the numerator is from CMS Net and CCS program data and for the denominator is from the publication: Social Security Administration Office of Policy, Children Receiving SSI.

Numerator: Children under 16 years of age enrolled in CCS with aid codes of 20 and 60 (disabled children with SSI) for FY 2008-09. Since active cases on CMS Net represent an estimated 74 percent of all active CCS cases for CA for FY 2008-09, the number with aid codes 20 and 60 from CMS Net is extrapolated for CA.

The denominator is from the Social Security Administration Office of Policy, Children Receiving SSI under 16 years of age for 2009.

Notes - 2008
This measure is the percent of SSI beneficiaries through age 15 years receiving rehabilitative services through the CCS program. Source of data for the numerator is from CMS Net and CCS program data and for the denominator is from the publication: Social Security Administration Office of Policy, Children Receiving SSI.
Numerator: Children under 16 years of age enrolled in CCS with aid codes of 20 and 60 (disabled children with SSI) for FY 2007-08. Since active cases on CMS Net represent an estimated 72.3 percent of all active CCS cases for CA for FY 2007, the number with aid codes 20 and 60 from CMS Net is extrapolated for CA.

There is a large increase in the number of children with aid code 60 for FY 2005-06 which can not be explained but is more consistent with data in FY 2001-02 and FY 2002-03, and is more in line with what would be anticipated.

The denominator is from the Social Security Administration Office of Policy, Children Receiving SSI under 16 years of age for 2008.

Notes - 2007
This measure is the percent of SSI beneficiaries through age 15 years receiving rehabilitative services through the CCS program. Source of data for the numerator is from CMS Net and CCS program data and for the denominator is from the publication: Social Security Administration Office of Policy, Children Receiving SSI.
Numerator: Children under 16 years of age enrolled in CCS with aid codes of 20 and 60 (disabled children with SSI) for FY 2006-07. Since active cases on CMS Net represent an estimated 69 percent of all active CCS cases for CA for FY 2006, the number with aid codes 20 and 60 from CMS Net is extrapolated for CA.

There is a large increase in the number of children with aid code 60 for FY 2005-06 which can not be explained but is more consistent with data in FY 2001-02 and FY 2002-03, and is more in line with what would be anticipated.

The denominator is from the Social Security Administration Office of Policy, Children Receiving SSI under 16 years of age for 2007.

Narrative:
Health Systems Capacity Indicator 08 (HSCI-8) is the percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State CSHCN Program. HSCI-8 is 30.1 percent for FY 2008-09, compared to 28.2 percent in the previous year. The numerator, 20,907 (25,534 FY 2007-08), is the number of open CCS cases under 16 years of age with aid codes of 20 and 60. The denominator, 93,899 (90,464 for FY 2007-08), is the percent of SSI beneficiaries less than 16 years old receiving rehabilitative services from the CSHCN Program.

There have been several changes in how this indicator has been calculated over the last few years. The current methodology is as follows. The numerator is the number of children in the CMS Net system with eligibility aid codes of 20 or 60 (disabled children with SSI), most of whom will be receiving MTP services. The denominator is from the Social Security Administration Office of Policy, Children Receiving SSI for December, the midpoint of the current fiscal year, for

children under 16 years of age.

The CCS MTP provides physical therapy, occupational therapy, and Medical Therapy Conference services to children who meet specific medical eligibility criteria. The majority of children have cerebral palsy. The children eligible for the MTP do not have to meet the CCS financial requirement to receive therapy or conference services through the MTP. Services are provided in a MTU, an outpatient clinic setting that is located on a public school site. Coordination of services in the MTU is under the medical management of a physician/therapy team.

MTU Online is a separate web-based software program for clinical documentation of MTU services. Twenty one counties are actively using MTU Online as of January 2009. This software allows for single entry of clinical data and narrative description by occupational and physical therapists and Medical Therapy Conference physicians.

Statewide clinical data is collected annually for MTP program management. The Functional Improvement Score is used to measure the amount of functional change that a child achieves in a 6-12 month. The Neuromotor Impairment Severity Scale measures the amount of neuromotor impairment for children with cerebral palsy or similar upper motor neuron conditions. Data analysis is limited due to budget cuts and it is projected that it will take several years to develop meaningful baselines and targets for program management.

The MTP module has moved to the web as of March 27, 2010. This web based administrative module is used to search, track, enter, modify, and report administrative data related to MTP.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2008	payment source from birth certificate	6.7	6.9	6.8

Notes - 2011
Source: State of California, Department of Public Health, Center for Health Statistics, 2008 California Birth Statistical Master File.

Expected payer source for delivery was used. Infants with missing birth weight were subtracted when calculating the percentages. Infants with missing payer source are included in the Total. Tabulations (by place of residence) were done by the MCAH Program.

Narrative:
Health Systems Capacity Indicator 05a (HSCI-5a) compares Medicaid and non-Medicaid in the percent of low birth weight (<2,500 grams) babies. In California, Medicaid is called Medi-Cal. Payment source data are obtained from birth certificates. Non-Medi-Cal payment sources include private insurance, self-pay, no charge, other government programs, and medically indigent. HSCI 05a decreased from 6.8 in 2007 to 6.7 in 2008 for Medicaid clients but not for non-Medicaid clients. African Americans covered by Medicaid had a rate of 12.8% compared to 11.9% among those not covered by Medicaid.

Various MCAH programs work to decrease the incidence of low birth weight (LBW < 2500 grams)

infants by providing at-risk women with comprehensive services including prenatal care, education, and psychosocial support. Over 1,500 Medi-Cal obstetrical practitioners provide CPSP services, serving approximately 165,000 women annually.

A primary goal of AFLP is to improve birth outcomes for babies born to adolescent clients, many of whom receive Medi-Cal services. AFLP assists pregnant adolescents to access prenatal and other necessary health care early in pregnancy, provides nutritional counseling, and works with teens to eliminate behaviors contributing to poor birth outcomes.

African American infants are more than twice as likely as infants of other racial/ethnic groups to be born with LBW in California. BIH identifies pregnant and parenting African American women at risk for poor birth outcomes and assists them in accessing and maintaining appropriate health care and supportive services. BIH serves on average over 3,500 pregnant and parenting African American women and infants monthly.

MCAH and CMS collaborate with CPQCC which advocates for performance improvement in perinatal and neonatal outcomes. CPQCC has 128 member hospitals, accounting for over 90 percent of newborns requiring critical care.

RPPC provides consultation to delivery hospitals, using current outcomes data from Perinatal Profiles. RPPC supports implementation of clinical quality improvement strategies by collaborating with maternal and neonatal providers to address evidence-based quality improvement projects and improve risk-appropriate care.

MCAH participates in PHCC, providing information, tools and resources to local communities on achieving optimal health for women prior to pregnancy. MCAH and CMS collaborate with March of Dimes on its multi-year Prematurity Campaign (2003-2010), the goal of which is to invest in research, education and community programs to identify causes of prematurity and develop strategies to improve birth outcomes. Both also participate in the Premature Infant Health Coalition, a public-private effort organized by the March of Dimes California Chapter and Med Immune in late 2007 to reduce the rate of premature births in the state and improve outcomes for children born prematurely.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2007	matching data files	5.6	4.7	5.3

Notes - 2011

Source: State of California, Department of Public Health, Center for Health Statistics, 2007 Birth Cohort file.

Expected payer source for delivery was used to compute rates. Cases with missing payer source included in Total. Tabulations (by place of residence) were done by the MCAH Program.

Narrative:

HSCI-5b compares Medi-Cal and non-Medi-Cal infant death rates. Payment source data are obtained from birth certificates. Non-Medi-Cal payment source includes private insurance, self-pay, no charge, other government programs, and medically indigent.
The infant death rate was higher among Medi-Cal births (5.6 per 1,000) than among non-Medi-Cal births (4.7 per 1,000) in 2007. The infant death rate for Medi-Cal births decreased in 2007 but increased for non-MediCal births. Neither the Medi-Cal births nor the non-Medi-Cal births achieved the Healthy People 2010 goal of 4.5 per 1,000 in 2007.

The disparity by payor was most apparent for Whites, for whom the infant death rate was much higher for Medi-Cal (6.3 per 1,000) than for non-Medi-Cal (4.2 per 1,000) births. Infant death rates at 12.3 per 1000 were highest for MediCal births among African Americans. Infant death rates for non-Medi-Cal African Americans were at 11.3 per 1,000.

CDRTs make recommendations on ways to prevent infant deaths and take findings to action. SAC Branch has completed trainings for CDRTs to promote the recruitment of injury prevention specialists to strengthen their prevention recommendations. The Safe Surrender Baby Law and remedies for unsafe sleeping environments and practices have been emphasized by CDRTs.

MCAH is the lead within CDPH in reducing infant mortality. MCAH developed an action plan to address the infant mortality rate disparities.

In June 2009, MCAH completed BIH-FIMR 3-year pilot whose goal is to reduce African American fetal/ infant deaths through death case reviews and implementation of interventions through collaborative community involvement. BIH-FIMR LHJs collected information about African American fetal and infant deaths using the Baby Abstracting System and Information NETwork (BASINET), a web-based database. Use of the BASINET system will be discontinued since it did not adequately meet their needs or state MCAH needs.

Sixteen LHJs implement the national FIMR model. In the Contra Costa County FIMR program, preconception/interconception education has been integrated into the maternal interview. The interview is an essential component in the spectrum of case management and family support services offered to clients following a fetal or infant death. Given its size and large number of birthing hospitals, L.A. County uses a survey tool, the L.A. Health Overview of a Pregnancy Event to conduct its FIMR program. The survey questions are designed to focus on maternal behaviors and health system variables that can be addressed by public health interventions.

All MCAH LHJs conduct outreach to encourage pregnant women to seek early prenatal care such as the Perinatal Care Guidance. Many LHJs integrate preconception and interconception messaging into their services as a strategy to prevent poor birth outcomes such as infant mortality.

Various MCAH programs focused on decreasing the incidence of infant mortality include CPSP, AFLP, BIH, RPPC and PHHI.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**

Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2008	payment source from birth certificate	76	88	82.4

Notes - 2011
Source: State of California, Department of Public Health, Center for Health Statistics, 2008 California Birth Statistical Master File.

Payer source for prenatal care was used. Women with missing prenatal care initiation were subtracted from the denominator when calculating the percent shown. Women with missing payer source included in Total. Tabulations (by place of residence) were done by the MCAH Program.

Narrative:
Health Systems Capacity Indicator 05c (HSCI-05c) compares Medi-Cal and non-Medi-Cal on first trimester prenatal care. Payment source data are obtained from birth certificates. Non-Medi-Cal payment source includes private insurance, self-pay, no charge, other government programs, and medically indigent.

HSCI 5c decreased to 82.4% in 2008 compared to 82.9% in 2007 which continues a gradual decline over the past five years. The percent of women entering prenatal care in the first trimester was lower for Medi-Cal births (76 %) than for non-Medi-Cal births (88 %) in 2008. This difference was noted for all race/ethnic groups.

One of the goals of many state MCAH programs, including local MCAH, AFLP and BIH is to identify women in need of prenatal care and connect them to services within the first trimester. Local MCAH programs develop specific strategies to improve access to early prenatal care in their communities. For example, the San Joaquin County health department obtained external funding to fund a "Go Before You Show" public education campaign that encourages women to access early prenatal care. In L.A. County, MCAH staff updated and expanded perinatal resources available through its 211 line and are improving visibility of this resource, especially in lower income communities. However, despite these successful strategies, numerous barriers prevent women from accessing early prenatal care.

Unintended pregnancies are associated with lower rates of first trimester prenatal care utilization.[34] One of the goals of PHCC, is to address unintended pregnancy by encouraging reproductive life planning (RLP). CFHC, a PHCC member, completed a three-year demonstration project to integrate preconception health and reproductive life planning messages into Title X- funded clinics, with the goal that all family planning clinic clients participate in RLP by 2015. MCAH has conducted focus groups with women about the concept of RLP and will be developing culturally appropriate RLPs in collaboration with the PHCC over the coming years. Another PHCC project, undertaken by ACOG, Region 9, and the March of Dimes California Chapter, is developing clinical guidelines for the post-partum visit that will help providers to address issues such as pregnancy spacing, care for chronic conditions between pregnancies and timely prenatal care for subsequent pregnancies.

The revised BIH model that will be piloted in October 2010 includes reproductive life planning and pregnancy spacing in its assessment and case management components as a way to address the high rates of unintended pregnancy in the African-American community.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2008	payment source from birth certificate	75	82.4	79

Notes - 2011
Source: State of California, Department of Public Health, Center for Health Statistics, 2008 California Birth Statistical Master File.

Payer source for prenatal care was used. Women with missing prenatal care values were subtracted from the denominator when calculating the percent shown. Women with missing payer source included in Total. Tabulations (by place of residence) were done by the MCAH Program.

Narrative:
Health Systems Capacity Indicator 05d (HSCI-5d) compares Medi-Cal and non-Medi-Cal on the percent of women with adequate prenatal care (Kotelchuck Index). Payment source data are obtained from birth certificates. Non-Medi-Cal payment source includes private insurance, self-pay, no charge, other government programs, and medically indigent. In 2008, 75 percent of Medi-Cal women and 82.4 percent of non-Medi-Cal women had adequate prenatal care in 2008. The percent of Medi-Cal women with adequate prenatal care rose slightly from the previous year (74.7 percent), while the non-Medi-Cal percent again increased slightly from the previous year (81.9 percent). While California has made much progress and the rates have been increasing over the past few years, these rates are still considerably lower than the national Healthy People 2010 goal of 90 percent.

One of the goals of many state MCAH programs, including local MCAH, AFLP and BIH is to identify women in need of prenatal care and connect them to services within the first trimester. Local MCAH programs develop specific strategies to improve access to early prenatal care in their communities. For example, the San Joaquin County health department obtained external funding to fund a "Go Before You Show" public education campaign that encourages women to access early prenatal care. In L.A. County, MCAH staff updated and expanded perinatal resources available through its 211 line and are improving visibility of this resource, especially in lower income communities. However, despite these successful strategies, numerous barriers prevent women from accessing early prenatal care.

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The revised BIH model that will be piloted in October 2010 includes reproductive life planning and pregnancy spacing in its assessment and case management components as a way to address the high rates of unintended pregnancy in the African-American community.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2008	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2008	250

Notes - 2011
Source: 2008 Medicaid data supplied by California Department of Health Care Services, Medi-Cal (California's Medicaid) Eligibility Branch based on an All County Welfare Directors Letter No. 08-05) specifying the 2008 Federal Poverty Levels (FPLs) for various programs. http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c08-05.pdf

Notes - 2011
Source: 2008 State Children's Health Insurance Program (SCHIP) Eligibility Levels supplied by Managed Risk Medical Insurance Board (MRMIB), Eligibility, Enrollment & Marketing Division based on Eligibility Levels for the ACCESS To Mothers and Infants (AIM) Program.

The 250% of poverty levels reported by MRMIB represent the upper range level. For infants 0-1 years of age, the range is 200%-250%.

Narrative:
Health Systems Capacity Indicator 06a (HSCI-6a) compares the income eligibility requirements for Medicaid and the SCHIP for infants (ages 0 to 1). In California, the SCHIP program is called HF. Infants were eligible for Medi-Cal if the family income was at or below 200 percent of the FPL. Infants were eligible for HF if the family income was between 200 and 250 percent of FPL.

Three counties (San Francisco, Santa Clara, and San Mateo) are able to draw down federal matching funds for children who do not qualify for no-cost Medi-Cal or HF, as approved in our State Plan. Eligibility for SCHIP in these counties was 250-300% FPL for children ages 0 to 1.

Infants up to one year old born to women with family incomes between 200 and 300 percent of FPL and who were enrolled in AIM were eligible for 2 years in the AIM Program, provided the infant was not enrolled in no-cost Medi-Cal or employer-sponsored health insurance.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**

Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2008	 133 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2008	 250 250

Notes - 2011
Source: 2008 Medicaid data supplied by California Department of Health Care Services, Medi-Cal (California's Medicaid) Eligibility Branch based on an All County Welfare Directors Letter No. 08-05) specifying the 2008 Federal Poverty Levels (FPLs) for various programs. http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c08-05.pdf

Notes - 2011
Source: 2008 State Children's Health Insurance Program (SCHIP) Eligibility Levels supplied by Managed Risk Medical Insurance Board (MRMIB), Eligibility, Enrollment & Marketing Division based on Eligibility Levels for the ACCESS To Mothers and Infants (AIM) Program.

The 250% of poverty levels reported by MRMIB represent the upper range levels for each population group. Children 1 through 5 years of age have eligibility levels ranging from 133%-250% of FPL; children 6-18 years of age have eligibility levels ranging from 100%-250%.

Narrative:
Health Systems Capacity Indicator 06b (HSCI-06b) compares the income eligibility requirements for Medicaid (Medi-Cal) and SCHIP for children from 1 year up to age 19.

Children aged 1-5 years were eligible for Medi-Cal if the family income was at or below 133 percent of FPL; for children age 6-18, the eligibility level was 100 percent of FPL. Children aged 1-5 were eligible for HF with family incomes between 133 and 250 percent of FPL, and children aged 6-18 were eligible for HF if the family income was between 100 and 250 percent of FPL.

Three counties (San Francisco, Santa Clara, and San Mateo) are able to draw down federal matching funds for children who do not qualify for no-cost Medi-Cal or Healthy Families, as approved in our State Plan. Eligibility for SCHIP in these counties was 250-300% FPL for children aged 1-5 and 6-18 years.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2008	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**

Pregnant Women	2008	300

Notes - 2011
Source: 2008 Medicaid data supplied by California Department of Health Care Services, Medi-Cal (California's Medicaid) Eligibility Branch based on an All County Welfare Directors Letter No. 08-05) specifying the 2008 Federal Poverty Levels (FPLs) for various programs.
http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c08-04.pdf

Notes - 2011
Source: 2008 State Children's Health Insurance Program (SCHIP) Eligibility Levels supplied by Managed Risk Medical Insurance Board (MRMIB), Eligibility, Enrollment & Marketing Division based on Eligibility Levels for the ACCESS To Mothers and Infants (AIM) Program.

The 300% of poverty level reported by MRMIB represents the upper range. Eligibility levels for pregnant women range from 200-300% of FPL.

Narrative:
Health Systems Capacity Indicator 06c (HSCI-6c) compares the income eligibility requirements for Medicaid and SCHIP/HF for pregnant women.

Pregnant women are eligible for Medi-Cal with a family income at or below 200 percent of the FPL. Pregnant women with family income levels between 200 and 300 percent of the FPL are eligible for the AIM Program.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	Yes
Annual linkage of birth certificates and WIC eligibility files	3	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes

Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2011

Narrative:
Health Systems Capacity Indicator 09a (HSCI-9a) describes data access.
MCAH has access to linked birth and death files that are used for monitoring, analytic and research endeavors including assessment of mortality and morbidity rates and quality of care indicators. The Perinatal Profiles report provides annual perinatal data analyses confidentially to hospitals annually and is one of the primary tools for reducing fetal and infant mortality rates and improving quality of care.

MCAH has access to hospital discharge data through the OSHPD. OSHPD collects data from all hospitals in California, including data on population demographics, hospital/clinic characteristics, payer source, births and other conditions, procedures, and injuries. The discharge data are linked to birth and death data and are analyzed by MCAH.

MCAH has access to birth certificate data linked with genetic newborn screening data and birth defects registry data. MCAH also has access to Medi-Cal data. MCAH has linked birth certificate data and WIC prenatal services data.

MCAH's MIHA is an annual population-based survey of post-partum women in collaboration with UCSF. MIHA is modeled after CDC's PRAMS and is self-administered 10-14 weeks after birth to a random sample of women. Topics include pregnancy intention, healthcare utilization, breastfeeding, and health behaviors before and during pregnancy. Birth outcomes are provided through linkage with birth certificate data. UCSF staff collaborates with MCAH on survey analysis and reporting.

The California Women's Health Survey (CWHS), conducted by the Office of Women's Health, is an annual, anonymous, population-based, computer-assisted, telephone survey. Topics include health insurance status, family planning, sexually transmitted infections, pregnancy, mental health, and lifestyle issues. MCAH sit on the CWHS advisory group, contribute questions to the survey, analyze data and present findings.

CHIS, conducted by UCLA in collaboration with CDPH, DHCS, and PHI, is a statewide bi-annual telephone survey of adults, adolescents, and children. Topics include health insurance coverage, health behaviors, chronic disease, mental health, oral health, and lifestyle issues. MCAH sit on several CHIS Technical Advisory Groups, helping to develop topic areas and survey questions, and analyzing the data.

MCAH also collects data on its various programs, including AFLP, BIH, CDAPP, CPSP, FIMR, and SIDS. Data elements cover client socio-demographic information and service access information.

In order to improve the quality of birth certificate data, the Office of Vital Records (OVR) and MCAH are collaborating on providing 8 trainings beginning in March 2010 emphasizing the importance of hospital administration, nursing and birth clerks working together to accurately report birth data. RPPC will discuss opportunities for nursing staff to work with birth clerks for enhanced birth data reporting.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes
California Student Survey	3	No
California Health Interview Survey	3	Yes

Notes - 2011

Narrative:
HSCI 9b measures the ability of States to determine the percent of adolescents in grades 9-12 who report using tobacco products during the past month. California obtains data on adolescent tobacco use from multiple sources. These include the biennial California Youth Risk Behavior Survey (YRBS), the California Student Survey (CSS), and CHIS.

YRBS was implemented statewide for the first time in spring 2009 in schools using a random sample of 9th through 12th graders. The last survey was in 2007/2008 but only included four counties: L.A., San Bernardino, San Diego and San Francisco. The YRBS was developed to monitor priority health risk behaviors that contribute to the leading causes of mortality, morbidity and social problems among adolescents. The survey is part of a surveillance effort conducted by CDPH, CDE and the PHI in cooperation with the CDC. The biennial sample size for this survey is approximately 1,500 surveys.

CSS utilizes data from a voluntary, representative, randomly-selected biennial sample of schools and classrooms (seventh, ninth graders, and eleventh graders). CSS collects information on adolescent alcohol and other drug use patterns, including data on tobacco use (smoking), marijuana, and inhalants, along with physical activity, nutrition and eating habits, depression, and external and internal resilience enhancing assets. CSS allows for trend data analyses, and provides data on a range of health related behaviors comparable with the Youth Risk Behavior Survey (YRBS).

CHIS is a telephone survey of adults, adolescents, and children from all parts of the state. The survey is conducted every two years. CHIS is the largest state health survey and one of the largest health surveys in the United States and is able to provide statewide and local level estimates on a number of health related issues, including adolescent tobacco use. MCAH sit on several CHIS Technical Advisory Groups, helping to develop topic areas and survey questions, and analyzing the data.

The County and Statewide Archive of Tobacco Statistics web site, created by CDPH's Tobacco Control Program (CTCP) and the Tobacco Education Clearinghouse of California (TECC), provides access to a wide variety of tobacco-related data, information, and resources.

CTCP administers and coordinates statewide tobacco control efforts and administers the California Student Tobacco Survey. The annual Youth Tobacco Purchase Survey uses random, onsite inspections at retail sites by minors 15 and 16 years old to monitor illegal sales to adolescents.

IV. Priorities, Performance and Program Activities

A. Background and Overview

California's Title V performance reporting will include a total of twenty five to twenty eight measures: eighteen national performances measures (NPM) mandated by HRSA and seven to ten additional measures chosen by the state. The three SPM in this report include the following:

SPM 01: The percent of children birth to 21 years enrolled in the CCS program who have a designated medical home;
SPM 02: The percent of primary care physicians, approved to participate in the CCS program, who are receiving authorizations for care;
SPM 03: The percent of families of children, birth to 21 years enrolled in the CCS program, randomly selected by region who complete an annual satisfaction survey;

Data on performance measures are included in two parts of this report - on the data forms and in the narrative.

The three priorities currently identified targeting the CSCHN population were a result of the needs assessment conducted by CMS. The 2011-2015 CMS Five-year Needs Assessment process identified several priorities with the top three priorities included as part of this report. Following key informant interviews, focus group discussions, online-surveys, review of the 2005 CMS Needs Assessment priorities, consultation with CMS Branch state staff, and data analysis, 13 CMS priorities were identified and ranked. Stakeholders individually used the weighted criteria they had developed together and a tool provided by FHOP to rate each of the priority objectives. The individual rating scores were then aggregated to rank the priority objectives. The top 3 CMS priorities are listed as 1 to 3.

All ten of California's priorities have one or more related national or state performance measures.

B. State Priorities

The ten priorities for Title V activities in California and the associated performance measures and health indicators are:

>Priority 1: Modify the CCS program, with appropriate funding, to cover the whole child.
SPM 1 (new): The percent of children birth to 21 years enrolled in the CCS program who have all their health care provided by and coordinated by one health care system.
SPM 3(new): The percent of families of children, birth to 21 years enrolled in the CCS program, randomly selected by region who complete an annual satisfaction survey.
NPM 4: CSHCN age 0 to 18 whose families have adequate private and/or public insurance.
NPM 5: CSHCN whose families report the community-based service systems are organized so they can use them easily.
NPM 6: Youth with special health care needs who received the services necessary to make transition to all aspects of adult life.

>Priority 2: Expand the number of qualified providers of all types in the CCS program.
SPM 2 (new): The percent of primary care physicians, approved to participate in the CCS program, who are receiving authorizations for care.
NPM 3: CSHCN who receive coordinated, ongoing, comprehensive care within a medical home.
NPM 4: CSHCN age 0 to 18 whose families have adequate private and/or public insurance.
NPM 5: CSHCN whose families report the community-based service systems are

organized so they can use them easily.
NPM 6: Youth with special health care needs who received the services necessary to make transition to all aspects of adult life.

>Priority 3: CCS will work with appropriate partners to define and create and implement standards for Medical Homes for CCS children.
SPM 3 (new): The percent of families of children, birth to 21 years enrolled in the CCS program, randomly selected by region who complete an annual satisfaction survey.
NPM 2: CSHCN whose families partner in decision making at all levels and are satisfied with the services they receive.
NPM 3: CSHCN who receive coordinated, ongoing, comprehensive care within a medical home.

>Priority 4: Improve maternal health by optimizing the health of girls and women across the life course.
NPM 15: Percentage of women who smoke in the last three months of pregnancy.
SPM 3 (old): The percent of women, aged 18-44 years, who reported 14 or more "not good" mental health days in the past 30 days (frequent mental distress").
SPM 4 (old): The percent of women who reported drinking any alcohol in the first or last trimester of pregnancy.
SPM 8 (old): The percent of births resulting from an unintended pregnancy.
SPM 10 (old): The percent of women, aged 18 years or older, reporting intimate partner physical, sexual or psychological abuse in the past 12 months.

>Priority 5: Promote healthy nutrition and physical activity among MCAH populations throughout the lifespan beginning with exclusive breastfeeding of infants to six months of age.
NPM 11: The percent of mothers who breastfeed their infants at 6 months of age.
NPM 14: Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

>Priority 6: Reduce maternal morbidity and mortality and the increasing disparity in maternal health outcomes.
NPM 15: Percentage of women who smoke in the last three months of pregnancy.
NPM 17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates
NPM 18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.
SPM 10 (old): The percent of women, aged 18 years or older, reporting intimate partner physical, sexual or psychological abuse in the past 12 months.

>Priority 7: Reduce infant mortality and address disparities by promoting preconception health and health care and by preventing causes such as birth defects, low birth weight/prematurity, SIDS, and maternal complications in pregnancy.
NPM 15: Percentage of women who smoke in the last three months of pregnancy.
NPM 17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.
NPM 18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.
SPM 4 (old): The percent of women who reported drinking any alcohol in the first or last trimester of pregnancy.
SPM 6 (old): The incidence of neural tube defects (NTDs) per 10,000 live births plus fetal deaths among counties participating in the California Birth Defects Monitoring System

>Priority 8: Support the physical, socio-emotional, and cognitive development of children, including the prevention of injuries, through the implementation of prevention, early identification and intervention strategies.

NPM 1: The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.
NPM 2: The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive.
NPM 3: The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home.
NPM 4: The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need.
NPM 5: Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily.
NPM 6: The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.
NPM 7: Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.
NPM 9: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.
NPM 10: The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.
NPM 12: Percentage of newborns who have been screened for hearing before hospital discharge.
NPM 13: Percent of children without health insurance.
NPM 14: Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

>Priority 9: Promote positive youth development strategies to support the physical, mental, sexual and reproductive health of adolescents.
NPM 8: The rate of birth (per 1,000) for teenagers aged 15 through 17 years.
NPM 16: The rate (per 100,000) of suicide deaths among youths aged 15 through 19.
SPM 5 (old): The rate of deaths per 100,000 adolescents aged 15 through 19 years caused by motor vehicle injuries.
SPM 9 (old): The percent of 9th grade students who are not within the Healthy Fitness Zone for Body Composition.

>Priority 10: Link the MCAH population to needed medical, mental, social, dental, and community services to promote equity in access to quality services.
NPM 1: The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.
NPM 2: The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive.
NPM 3: The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home.
NPM 4: The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need.
NPM 5: Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily.
NPM 6: The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.
NPM 7: Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.
NPM 9: Percent of third grade children who have received protective sealants on at least one

permanent molar tooth.
NPM 12: Percentage of newborns who have been screened for hearing before hospital discharge.
NPM 13: Percent of children without health insurance.
NPM 17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.
NPM 18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	99.5	100	99.5	100	100
Annual Indicator	99.2	100.0	100.0	100.0	100
Numerator	478	566	609	607	
Denominator	482	566	609	607	
Data Source				Genetic Disease Screening Program, 2008	Genetic Disease Screening Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	100

Notes - 2009
A manual indicator is reported for 2009 based on 2008.

Notes - 2008
State of California, Department of Public Health, Genetic Disease Screening Program, 2008 Newborn Screening Records.

Newborn screening includes screening for the following conditions: PKU, congenital hypothyroidism, galactosemia, sickle cell disease, congenital adrenal hyperplasia, and non-PKU inborn errors of metabolism tested by tandem mass spectrometry, cystic fibrosis and biotidinase deficiency. In 2007, 47% of the screenings added cystic fibrosis and biotidinase deficiency. When looking at trends, it is also necessary to keep in mind that data prior to 2005 pertained to only the first four conditions (PKU, congenital hypothyroidism, galactosemia, and sickle cell disease), and that data for 2005 pertained to the first four for the entire year but added congenital adrenal

hyperplasia and non-PKU inborn errors of metabolism tested by tandem mass spectrometry in the last six months of that year.

Notes - 2007
State of California, Department of Public Health, Genetic Disease Screening Program, 2007 Newborn Screening Records.
Newborn screening includes screening for the following six conditions: PKU, congenital hypothyroidism, galactosemia, sickle cell disease, congenital adrenal hyperplasia, and non-PKU inborn errors of metabolism tested by tandem mass spectrometry. In addition, in July 2007 two more conditions were added to the screening: cystic fibrosis and biotidinase deficiency. In 2007, 47% of the screenings included these two newly included conditions.

When looking at trends, it is necessary to keep in mind that data prior to 2005 pertained to only the first four conditions, and that data for 2005 pertained to the first four for the entire year and to the last two for only the last six months of that year.

a. Last Year's Accomplishments
In 2008, GDSP detected and confirmed 607 genetic and congenital abnormalities as a result of its Newborn Screening (NBS) Program. California has effectively achieved universal coverage for NBS for genetic, metabolic and hematological disorders, with 100 percent of newborns screened for all conditions for which screening was mandated in 2006.

All the conditions for which the NBS Program screens, including over 40 metabolic disorders, endocrine disorders, and hemoglobinopathies, are CCS-eligible. GDSP and CMS have been collaborating to ensure that infants identified with abnormal metabolic, endocrine, sickle cell, or cystic fibrosis screening results from the current and expanded testing receive prompt diagnostic evaluations at one of the CCS-approved SCC in the state. The county CCS programs expedited GDSP referrals, so that infants with suspected illness can be identified and treated promptly in order to maximize prevention of premature death or serious disabilities. The guidelines for diagnostic follow-up and treatment of the over 40 additional metabolic disorders and congenital adrenal hyperplasia are in place.

In March 2009, the California Prenatal Screening Program expanded to allow 1st trimester specimens for Integrated Screening and will consist of 4 types of screening tests:

-Patients who submit a blood specimen in the 2nd trimester (15 to 20 weeks): Quad Marker Screening [AFP, hCG, uE3, and Inhibin]

-Patients who had CVS and submit a blood specimen in the 2nd trimester: Neural Tube Defect (NTD)/Sickle Cell Disease (SCD) Screening [Risk assessment for NTDs and SCD only]

-Patients that submit a blood specimen in the 1st trimester (10 to 13 weeks 6 days) and 2ndtrimester (15 to 20 weeks): Serum Integrated Screening [Pregnancy Associated Plasma Protein and hCG in the first trimester, plus Quad Marker Screening in the second trimester] -Full Integrated Screening:

- Nuchal Translucency Ultrasound when the crown rump length is between 45-84 mm, combined with Serum Integrated Screening.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. GDSP screens for genetic and congenital disorders, including			X	

testing, follow-up and early diagnosis of disorders to prevent adverse outcomes or minimize clinical effects				
2. GDSP ensures quality of analytical test results and program services by developing standards and quality assurance procedures, and monitoring compliance with them.				X
3. GDSP fosters informed participation in its programs through a combination of patient, professional, and public education, and accurate and up-to-date information and counseling.			X	
4. GDSP and CMS collaborate to ensure that infants identified with abnormal screening results receive prompt diagnostic evaluations at one of the CCS-approved Metabolic Special Care Centers (SCC) in the state.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CMS and GDSP programs work together to address issues as they arise and update policies and reporting forms as needed in an effort to ensure that babies who screen positive receive expedited care at a CCS approved Special Care Center. Although CCS makes a special effort to expedite these cases some slight delays may occur due to the CCS staffing cuts.

CCS provides services for conditions identified on newborn screening tests, develops standards, and approves Metabolic, Endocrine, Sickle Cell, and Cystic Fibrosis SCCs for treatment.

c. Plan for the Coming Year

GDSP will continue to screen for genetic and congenital disorders, including testing, follow-up and early diagnosis, in order to prevent adverse outcomes and minimize clinical effects. GDSP ensures the quality of analytical test results and program services by developing standards and quality assurance procedures, and monitoring compliance with them. GDSP fosters informed participation in its programs through a combination of patient, professional, and public education, as well as accurate, up-to-date information and counseling (e.g., Hemoglobin Trait Carrier Follow-up Program, Maternal PKU Program, GeneHELP Resource Center and the Sickle cell Counselor Training and Certification Program).

GDSP will continue to work collaboratively with state and local agencies, including CMS, CCS-approved SCCs, GDSP NBS Contract Liaisons and other NBS Program staff, local County CCS programs, and Area Service Center Project Directors and Medical Consultants to ensure that newborns identified with positive screening reports are quickly evaluated, diagnosed, and appropriately treated, and that families are informed and supported throughout the process.

GDSP will continue its research studies toward the possibility of screening for additional preventable and treatable genetic and congenital disorders.

GDSP will continue to administer and evaluate the 1st Trimester Prenatal Screening Program. CMS and GDSP will continue to work together to address issues as they arise and update literature as needed. Despite the decreased staff, CCS will attempt to expedite authorizations appropriate for diagnosis and treatment of babies with positive results from newborn screening.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**547702**					
Reporting Year:	**2008**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	547702	100.0	245	14	14	100.0
Congenital Hypothyroidism (Classical)	547702	100.0	507	299	299	100.0
Galactosemia (Classical)	547702	100.0	112	9	9	100.0
Sickle Cell Disease	547702	100.0	244	56	56	100.0
Cystic Fibrosis	547702	100.0	157	71	71	100.0
Congenital Adrenal Hyperplasia (Classical Salt Wasting)	547702	100.0	693	24	24	100.0
Biotinidase Deficiency (BD+ Partials)	547702	100.0	127	14	14	100.0
Tandem Mass Spectrometry (MS/MS) screening for non-PKU inborn errors of metabolism	547702	100.0	1373	0	0	
HIV Oraquick	23219	4.2	0	71	0	0.0
HIV Enzyme	14741	2.7	0	62	0	0.0
Expanded Alpha Fetoprotein (Prenatal Screening)	355005	64.8	19159	814	814	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	50.5	51.5	52.5	52.5	47
Annual Indicator	47.6	47.6	46.6	46.6	46.6
Numerator					
Denominator					
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	47.5	48	48.5	49	49.5

Notes - 2009
This measure is the percent of CSHCN age 0 to 18 years whose families partner in decision-making at all levels and are satisfied with the services they receive.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06.

Notes - 2008
This measure is the percent of CSHCN age 0 to 18 years whose families partner in decision-making at all levels and are satisfied with the services they receive.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06.

Notes - 2007
Section Number: Performance Measure #2
Field Name: PM02
Row Name:
Column Name:
Year: 2007
Field Note:
This measure is the percent of CSHCN age 0 to 18 years whose families partner in decision-making at all levels and are satisfied with the services they receive.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-

2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06.

a. Last Year's Accomplishments
NPM 02 is one of five measures (see also NPM 03, 04, 05, and 06) taken from the National Survey of CSHCN. Based on the 2005-2006 survey, 46.6 percent of CSHCN age 0 to 18 have families partnering in decision making at all levels and are satisfied with the services they receive.

The most recent National Survey of CSHCN (2005-2006), conducted by the Special Population Surveys Branch of the CDC National Center for Health Statistics (NCHS), identified approximately 750 parents of children with special needs in each state.

1) The Annual CRISS Conference held in 2009 was focused on mental health services for children and youth with special health care needs.

2) In 2009 the L.A. Partnership for Special Health Care Needs Children (LAPSNC), in collaboration with a consortium of organizations, presented an all day conference entitled, "Weathering Difficult Times: Resources for Children with Special Needs and their Families.

3) The CRISS-FCC Work Group continued to meet 4 to 5 times a year to share ideas and resources; coordinated conferences, trainings and activities; and monitor transition activities, parent liaison services, and medical home projects.

4) County CCS programs reported on family participation in the CCS program.

5) There has been collaboration among counties and agencies to provide workshops, resource fairs, and conferences for families; these collaborations included parents and families in the planning and development.

6) Family members participated on advisory committees or task forces in many counties, and became involved with in-service training of CCS staff and providers.

7) FVCA tracked emerging issues and statewide trends, identify solutions, and determine training needs.

8) FVCA provided 9 statewide webinars for families and professionals on a variety of topics from transition to nutrition.

9) FVCA Council held monthly meetings to address parent and community involvement.

10) "Kids As Self Advocates" (KASA) met once a month via conference call and face-to-face every other month. This group provided input to CMS on several issues and participated as a panelist at the annual "CCS Best Practices" conference.

11) FVCA collaborated with other groups and provided leadership training to 35 self-advocates and parents of children with developmental disabilities.

12) FVCA continued to work on the development of the FVCA Parent Leadership Training Curriculum to prepare families to partner in decision-making.

13) CMS included CSHCN stakeholder groups in the Needs Assessment process.

14) Families were included in a stakeholder group to recommend models to improve the delivery of care for CSHCN in the 1115 Waiver.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CMS will broaden its stakeholder group which includes family partnership to identify state priorities through the 2010 Needs Assessment process.				X
2. Family Voices and CMS are working together to enhance services for families of CYSHCN and involve families as partners in decision-making.		X		
3. The FCC Work Group of CRISS, comprised of 14 county programs, meets bimonthly to plan annual conferences, workshops, resource fairs, and address issues.				X
4. CCS programs are partnering with Family Resource Centers in their areas.		X		
5. CMS is partnering in the planning of annual educational FCC conferences (Northern and Southern California) for CCS administrators, medical, nurse and social work consultants, parent health liaison/leaders, and therapists.		X		
6. County CCS programs evaluate and report their family participation in their programs.				X
7. The FCC Work Group is providing technical assistance for CCS administrators for hiring or contracting a parent liaison.				X
8. County agencies and families are collaborating to provide workshops, resource fairs, and conferences for families of CSHCN.		X		
9.				
10.				

b. Current Activities

1) CSHCN stakeholder groups participate in the Needs Assessment process.

2) Family groups participate in the process to improve the delivery of care for CSHCN in the 1115 Waiver.

3) The CRISS-FCC Work Group continued to meet 4 to 5 times a year to share ideas and resources; coordinated conferences, trainings and activities; and monitor transition activities, parent liaison services, and medical home projects.

4) LAPSNC, collaborates with organizations and parent groups to plan meetings and conferences.

5) County CCS programs collaborate with agencies and families to plan conferences and report on family participation in the CCS program.

6) FVCA work with the CCS Parent Health Liaison (PHL) to track emerging issues and statewide trends, identify solutions, and determine training needs.

7) FVCA Council holds monthly meetings to address parent and community involvement.

8) KASA meet once a month via conference call and face-to-face every other month. This group

provides input to CMS on several issues.

9) FVCA collaborates with other groups to provide leadership training to advocates and parents of children with developmental disabilities.

10) FVCA updates the Parent Leadership Training Curriculum to prepare families to partner in decision-making for the care of their children.

c. Plan for the Coming Year

1) CSHCN stakeholder groups will be included in the implementation of priorities selected through the Needs Assessment process.

2) Families included in stakeholder groups will continue to participate in activities to improve the delivery of care for children with special health care needs through the 1115 Waiver.

3) Family members will participate on advisory committees and will b in-service training of CCS staff and providers

4) FVCA will support the PHL services and provide trainings to the PHLs to assist families.

5) FVCA will facilitate the PHL's monthly conference calls to discuss local activities, provide technical support, track families' issues, identify statewide trends, and determine training needs.

6) FVCA will meet with CMS as the Family Advisory Group and respond to requests for input on materials and committees.

7) FVCA will hold monthly KASA meetings, both face-to-face and by phone, to ensure their ability to provide input to CMS.

8) FVCA will provide trainings to families and professionals so families can partner in the decision-making process.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	48	50	51	51	42.5
Annual Indicator	44.7	44.7	42.2	42.2	42.2
Numerator					
Denominator					
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

	2010	2011	2012	2013	2014
Annual Performance Objective	43	43.5	44	44.5	45

Notes - 2009
This measure is the percent of CSHCN in the State age 0 to 18 years who receive coordinated, ongoing, comprehensive care within a medical home.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005 - 06.

Notes - 2008
This measure is the percent of CSHCN in the State age 0 to 18 years who receive coordinated, ongoing, comprehensive care within a medical home.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005 - 06.

Notes - 2007
Section Number: Performance Measure #3
Field Name: PM03
Row Name:
Column Name:
Year: 2007
Field Note:

This measure is the percent of CSHCN in the State age 0 to 18 years who receive coordinated, ongoing, comprehensive care within a medical home.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.
Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005 - 06.

a. Last Year's Accomplishments
NPM 03 is from the National CSHCN Survey. Based on the 2005-2006 survey, 42.2 percent of the CSHCN in California receive coordinated, ongoing, comprehensive care within a medical home. The most recent National Survey of CSHCN (2005-2006), conducted by the Special Population Surveys Branch of the CDC- NCHS, identified approximately 750 parents of children with special needs in each state. CCS collaborated with CHLA and the California Epilepsy Foundation on a grant from HRSA, "Improving Access to Care for Children and Youth with Epilepsy in California," also known as "Project Access." Project Access was completed in May,

2009.

1) CRISS convened the project's local oversight committee and the FQHC to continue to support medical homes for children with epilepsy.

2) County CCS programs assessed CCS eligible children to determine if they have a documented medical home and explore improvement strategies.

3) The "Hospital Discharge Questionnaire" developed by FVCA and PHL Network, was provided to families to improve the coordination of care for their child when they come home from the hospital and is available in English, Spanish, and Chinese.

4) Child Health Notebooks to help organize healthcare information and medical records were distributed (also available electronically) in the 14 CRISS counties.

5) FVCA provided trainings for families and professionals on the Medical Home Initiative and distributed binders to help families organize healthcare information and medical records.

6) The "resource referral pads" are distributed by CRISS and are available on their website.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collaborate with USC's UCEDD at CHLA, CRISS, and FVCA, on Project Access to increase the number of medical homes for children with epilepsy in Sonoma County.		X		
2. County CCS programs assess CCS eligible children to determine if they have a documented medical home and explore improvement strategies.				X
3. The "Hospital Discharge Questionnaire" developed by FVCA and the PHL Network, is provided to families to improve the coordination of care for their child when they come home from the hospital.				X
4. Child Health Notebooks to help organize healthcare iinformation and medical records are distributed (also available electronically) in the 14 CRISS counties.				X
5. FVCA provides trainings for families and professionals on the Medical Home Initiative and distributes binders to help families organize healthcare information and medical records.				X
6. FVCA Agencies provide a “resource referral pads” to physicians that list local resources for families.				X
7.				
8.				
9.				
10.				

b. Current Activities

1) Although Project Access has ended, Sonoma County CCS continues to collaborate and support the medical home development for children with epilepsy in Sonoma County.

2) County CCS programs continue to assess whether CCS eligible children have a documented medical home, and explore improvement strategies.

3) The "Hospital Discharge Questionnaire," developed by FVCA and the PHL Network, is provided to families to improve the coordination of care for their child when they come home from the hospital and is available in English, Spanish, and Chinese.

4) Child Health Notebooks to help organize healthcare information and medical records are distributed in the 14 CRISS counties.

5) FVCA provides trainings for families and professionals on the Medical Home Initiative and distributes binders to help families organize healthcare information and medical records.

6) FVCA agencies provide "resource referral pads" to physicians listing local resources for families.

c. Plan for the Coming Year

Plans for the coming year include:

1) Sonoma County CCS will continue to collaborate and support the medical home development for children with epilepsy in Sonoma County.

2) Continue evaluation by county CCS programs to determine if children have a medical home and explore improvement strategies.

3) The "Hospital Discharge Questionnaire," developed by FVCA and the PHL Network, will be provided to families to improve the coordination of care for their child when they come home from the hospital and is available in English, Spanish, and Chinese.

4) Child Health Notebooks to help organize healthcare information and medical record will be distributed in the 14 CRISS counties and also made available electronically.

5) FVCA will continue to provide trainings for families and professionals on Medical Home and distribute binders to help families organize healthcare information and medical records.

6) FVCA Agencies will provide "resource referral pads" to physicians, listing local resources for families.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	64.5	65.5	68.5	65.5	60
Annual Indicator	59.3	59.3	59.6	59.6	59.6
Numerator					
Denominator					
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	60.3	60.6	61	61.3	61.6

Notes - 2009
This measure is the percent of CSHCN age 0 to 18 years whose families have adequate private and/or public insurance to pay for the services they need.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06.

Notes - 2008
This measure is the percent of CSHCN age 0 to 18 years whose families have adequate private and/or public insurance to pay for the services they need.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06.

Notes - 2007
Section Number: Performance Measure #4
Field Name: PM04
Row Name:
Column Name:
Year: 2007
Field Note:

This measure is the percent of CSHCN age 0 to 18 years whose families have adequate private and/or public insurance to pay for the services they need.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06.

a. Last Year's Accomplishments
NPM 04 is from the CSHCN Survey and is related to population-based services. For the 2005-2006 survey, 59.6 percent of families of CSHCN age 0 to 18 years in California had adequate private and/or public insurance to pay for the services they needed. The most recent National Survey of CSHCN (2005-2006), conducted by the Special Population Surveys Branch of the CDC National Center for Health Statistics, identified approximately 750 parents of children with special

needs in each state.

The CMS Branch determines whether CCS eligible children had access to private health coverage utilizing DHCS' Other Health Coverage (OHC) file. When the CMS Branch learned that a child had coverage not shown on the OHC file, it added this information to the file. CHDP programs and providers continued to identify and "deem" certain infants less than one year of age as eligible for ongoing, full-scope, no cost Medi-Cal at the time of a CHDP Health Assessment. The CMS Branch continued to work with HF and the AIM program to facilitate enrollment eligible infants into HF and those with CCS eligible conditions into the CCS program.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CMS Branch continues to determine whether CCS eligible children have access to private health coverage utilizing DHCS' Other Health Coverage (OHC) file.		X		
2. CHDP programs and providers are identifying and "deeming" certain infants less than one year of age as eligible for ongoing, full scope, no cost Medi-Cal at the time of a CHDP Health Assessment.		X		
3. CMS Branch continues to work with HF and the AIM program to facilitate enrollment of eligible infants into HF and those with CCS eligible conditions into the CCS program.		X		
4. CMS Branch will continue to implement the CHDP Gateway and identify CCS-eligible children through the Gateway process.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1) The CMS Branch continues to work with HF and the AIM program to facilitate enrollment of eligible infants into HF and those with CCS eligible conditions into the CCS program.

2) The CMS Branch continues to update the OHC file as health coverage information is obtained.

3) The CMS Branch continues to implement the CHDP Gateway and identify CCS eligible children through the Gateway process.

4) The CMS Branch participates in health care financing discussions at various levels of state government.

c. Plan for the Coming Year

1) The CMS Branch will continue to collaborate with various stakeholders in helping to ensure that families of CSHCN continue to receive necessary services. The CHDP Gateway pre-enrollment process serves as a means of assisting Medi-Cal eligible children and youth to access periodic preventive health assessments and the CMS Branch continues to support this process.

2) As resources become available, develop strategies to refer children enrolled in CCS to all

sources of available insurance, including Healthy Families, county Healthy Kids programs, Kaiser Permanente (KP) Care for Kids, and Medicaid waiver programs as appropriate.

3) As resources become available, link state and local CCS programs and other agencies serving CSHCN with funded outreach programs and projects promoting insurance coverage for children (e.g., Governor's coverage initiatives, other campaigns).

4) As resources become available, review existing Medicaid waivers and consider opportunities for expansion to include additional youth, e.g., for Medi-Cal "deeming" for additional youth with special health care needs.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	69	70	71	85.5	86
Annual Indicator	65.9	65.9	85.3	85.3	85.3
Numerator					
Denominator					
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	86.5	87	87	87	87.5

Notes - 2009
This measure is the percent of CSHCN age 0 to 18 years whose families report the community-based service systems are organized so they can use them easily.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06.

Notes - 2008
This measure is the percent of CSHCN age 0 to 18 years whose families report the community-based service systems are organized so they can use them easily.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-

2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06.

Notes - 2007
Section Number: Performance Measure #5
Field Name: PM05
Row Name:
Column Name:
Year: 2007
Field Note:
This measure is the percent of CSHCN age 0 to 18 years whose families report the community-based service systems are organized so they can use them easily.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06.

a. Last Year's Accomplishments
NPM 05 is a National CSHCN Survey measure and is the percent of CSHCN age 0 to 18 years whose families report that community-based service systems are organized so they can use them easily. For California in 2005-2006, the result was 85.3 percent.

The most recent National Survey of CSHCN (2005-2006), conducted by the Special Population Surveys Branch of the CDC National Center for Health Statistics, identified approximately 750 parents of children with special needs in each state.

1) CRISS Medical Eligibility Work Group met quarterly with CCS medical consultants, hospital and pediatric representatives to improve consistency in inter-county interpretation of CCS law and regulation.

2) CHDP, Health Care Program for Children in Foster Care (HCPCFC), and CCS programs reported on a performance measure evaluating effective care coordination.

3) LAPSNC focused on increasing parent involvement by inviting representatives from the Family Resources Centers (FRC) to meetings, and joining committees.

4) FVCA Council Agencies worked with their local CCS agency to provide trainings to CCS employees, and connect families to FRC for community resources, support and information.

5) The CRISS FCC Work Group met bimonthly to review county FCC activities, share resources, and plan conferences, trainings, and activities.

6) The CMS Branch, in partnership with Medi-Cal, submitted the Pediatric Palliative Care Waiver application to the federal Centers for Medicare and Medicaid Services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CRISS Medical Eligibility Work Group meets quarterly with CCS medical consultants, hospital and pediatric representatives, to improve consistency in inter-county interpretation of CCS law, regulation.				X
2. CHDP, HCPCFC, and CCS programs report on a performance measure evaluating effective care coordination.				X
3. LAPSNC focuses on increasing parent involvement by inviting representatives from the Family Resources Centers (FRC) to meetings, and joining committees.				X
4. FVCA Council Agencies work with their local CCS agency to provide trainings to CCS employees, and connect families to Family Resource Centers for community resources, support and information.				X
5. The FCC Work Group meet bimonthly to review county FCC activities, share resources, and plan conferences, trainings, and activities.				X
6. CMS Branch and the Medi-Cal program collaborate on the implementation of a pediatric Palliative Care program				X
7.				
8.				
9.				
10.				

b. Current Activities

1) CRISS Medical Eligibility Work Group (CCS medical consultants, hospital and pediatric Representatives) meets quarterly to improve consistency in inter-county interpretation of CCS law, regulation and policy regarding medical eligibility and benefits in the now 25-county CRISS region.

2) CHDP, HCPCFC, and CCS programs report on a performance measure evaluating effective care coordination.

3) LAPSNC works on increasing parent involvement by inviting representatives from the FRC to meetings, and joining committees.

4) FVCA Council Agencies work with their local CCS agency to provide trainings to CCS employees, and connect families to Family Resource Centers for community resources, support and information.

5) The FCC Work Group meets bimonthly to review county FCC activities, share resources, and plan conferences, trainings, and activities.

6) The CMS Branch and the Medi-Cal program collaborate on the implementation of a Pediatric Palliative Care program.

c. Plan for the Coming Year

Plans for the coming year include:

1) CRISS Medical Eligibility Work Group (CCS medical consultants, hospital and pediatric

Representatives) will continue to meet quarterly to improve consistency in inter-county interpretation of CCS law, regulation and policy regarding medical eligibility and benefits in the now 25-county CRISS region.

2) CHDP, HCPCFC, and CCS programs will report on a performance measure evaluating effective care coordination.

3) LAPSNC will continue to focus on increasing parent involvement by inviting representatives from the Family Resources Centers (FRC) to meetings, and joining committees.

4) FVCA Council Agencies will work with their local CCS agency to provide trainings to CCS employees, and connect families to FRC for community resources, support and information.

5) The CMS Branch and the Medi-Cal program will collaborate on the implementation of a Pediatric Palliative Care program.

6) LAPSNC is planning a conference related to identifying resources in challenging economic times for CSHCN and their families.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		5.8	5.8	37.5	37.5
Annual Indicator	5.8	5.8	37.1	37.1	37.1
Numerator					
Denominator					
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	38	38	38.5	38.5	39

Notes - 2009
This measure is the percent of youth with special health care needs in California who receive the services necessary to make transitions to all aspects of adult life.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06.

Notes - 2008
This measure is the percent of youth with special health care needs in California who receive the services necessary to make transitions to all aspects of adult life.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06.

Notes - 2007
Section Number: Performance Measure #6
Field Name: PM06
Row Name:
Column Name:
Year: 2007
Field Note:
This measure is the percent of youth with special health care needs in California who receive the services necessary to make transitions to all aspects of adult life.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06.

a. Last Year's Accomplishments
NPM 06 is a National CSHCN Survey measure and is the percentage of youth who received the services necessary to make transitions to all aspects of adult life. For California in 2005-2006, the result was 37.1 percent.

The most recent National Survey of CSHCN (2005-2006), conducted by the Special Population Surveys Branch of the CDC NCHS, identified approximately 750 parents of children with special needs in each state.

1) CCS social work consultants met quarterly and discuss transition issues.

2) The CMS Branch convened the Transition Task force to improve systems of care for CSHCN.

3) CMS staff collaborated with KASA via conference calls on issues surrounding transition. One particular topic was a "Transition Toolkit" designed for youth with disabilities. The toolkit is entitled

"Things are About to Change" A Young Person's Guide to Transitioning to Adulthood", and will be available fall 2010.

4) As staffing allowed, the CMS Branch staff collaborated with the Statewide Workgroup on the Transition of Care for CSHCN and developed the Branch's Transition Health Care Planning Guidelines for CCS programs. The Guidelines were released April 30, 2009, as a CCS Information Notice.

5) CMS staff met quarterly with FVCA council members and PHL to develop strategies to improve transition for CSHCN to adult health care providers.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Counties continue to be involved in the implementation and evaluation of transition strategies.				X
2. CMS Branch continues to meet with the Transition Workgroup to develop statewide guidelines and procedures for transition of care for CSHCN.				X
3. CMS social work consultants continue to meet on transition issues.		X		
4. State CMS staff will continue to instruct CCS-approved SCCs and those newly applying for approval on the importance and methods of integrating transition planning into patient care beginning at age 14 years.				X
5. CMS staff will continue to meet quarterly with FVCA council members and PHL to develop strategies to improve transition for CSHCN to adult health care providers.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1) CMS social work consultants continue to meet on transition issues.

2) State CMS staff continues to instruct CCS-approved SCCs and those newly applying for approval on the importance and methods of integrating transition planning into patient care beginning at age 14 years.

3) CMS continues to collaborate with Counties, Family Voices, and the KASA group on transition issues for CSHCN.

4) As staffing allows, the CMS staff meets with FVCA council members and PHL to develop strategies to improve transition for CSHCN to adult health care providers.

c. Plan for the Coming Year

1) CMS social work consultants will continue to meet on transition issues.

2) State CMS staff will continue to instruct CCS-approved SCCs and those newly applying for

approval on the requirements and methods of integrating transition planning into patient care beginning at age 14 years.

3) CMS will continue to collaborate with Counties, FVCA, and the KASA group on transition issues for CSHCN.

4) As staffing allows, the CMS staff will meet with FVCA council members and PHL to develop strategies to improve transition for CSHCN to adult health care providers.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	78	82	78.4	78.9	79.4
Annual Indicator	77.9	80.3	79.4	80.6	80.6
Numerator	410274	433605	432828	433234	
Denominator	526667	539981	545123	537511	
Data Source				National Immunization Survey, 2008	National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	79.9	80.4	80.9	80.9	80.9

Notes - 2009
A manual indicator is reported for 2009 based on 2008.

Notes - 2008
Source of percent immunized: Estimated Vaccination Coverage with Individual Vaccines and Selected Vaccination Series Among Children 19-35 Months of Age by State and Local Area US, National Immunization Survey, Q1/2008-Q4/2008. Available at: http://www.cdc.gov/vaccines/stats-surv/nis/tables/08/tab03_antigen_state.xls. Last accessed on September 1, 2009. Data for the 4:3:1:3:3 immunization series used.

Denominator: The number of two-year olds in the given year is from the California Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000–2050. Sacramento, CA, July 2007. Numerators are estimates derived by multiplying the percent of immunized children by the denominator.

Notes - 2007
Source of percent immunized: Estimated Vaccination Coverage with Individual Vaccines and Selected Vaccination Series Among Children 19-35 Months of Age by State and Immunization Action Plan Area, US, National Immunization Survey, 2007. Available at: http://www2a.cdc.gov/nip/coverage/nis/nis_iap.asp?fmt=v&rpt=tab03_antigen_state&qtr=Q1/2007-Q4/2007. Last accessed on October 10, 2008. Data for the 4:3:1:3:3 immunization series used.

Denominator: The number of two-year olds in the given year is from the California Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000–2050. Sacramento, CA, July 2007. Numerators are estimates derived by multiplying the percent of immunized children by the denominator.

a. Last Year's Accomplishments
LHJs continued to support immunization efforts on many levels, with activities that included trainings to providers and policy makers, professional and public outreach, participation in Coalitions with key partners, establishment of new clinic sites, referrals linking families to immunization services, provision of technical assistance and evaluation of local immunization data to determine follow-up strategies to increase rates. The percent of 19-35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza and Hepatitis B decreased from 81.4 percent in 2007 to 80.6 percent in 2008.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCAH and CMS advocate for eligible children to join Medi-Cal or HF, both of which cover immunization.		X		
2. Healthy Start (HS), the Health Insurance Plan of California, and Access for Infants and Mothers (AIM) provide health care access, including immunizations, for children.			X	
3. Health promotion for adequate immunizations is also done through the CHDP Gateway and AFLP, BIH, and CPSP.				X
4. Nine regional immunization registries, covering 53 of 58 California counties, provide the foundation for a centralized system of maintaining immunization records.				X
5. Based on data from the regional immunization registries, pockets of need are identified, and interventions are developed.				X
6. Efforts are underway to improve the electronic exchange of information for patients moving between regions, and to allow schools, childcare centers, Medi-Cal, WIC, and Cal-WORKS to link into regional registries.			X	
7. MCAH staff participate in a variety of ongoing activities, including serving on local Immunization Coalitions, participating in health fairs, providing trainings to providers, making referrals, evaluating data & establishing immunization clinic sites			X	
8.				
9.				
10.				

b. Current Activities
MCAH and CMS advocate for families to enroll in Medi-Cal or HF. With more children having access to primary and preventive care, the number of children receiving immunizations should increase. LHJs, including AFLP and BIH, continue to assess the immunization status of

adolescent and women clients and their children on a periodic schedule, and promote the importance of maintaining up-to-date immunizations by assisting program clients to access ongoing preventive care.

Due to the focus on H1N1, many local MCAH programs have focused activities on influenza immunization this year. Additionally, many LHJs participate on Immunization Collaboratives and Coalitions provide immunization through health fairs; and conduct public health immunization clinics.

Alameda County has an extensive immunization assistance program. In 08/09 they conducted Immunization Assistance Program: 25 immunization trainings, 100 consultations to providers, added 8 new providers and participation in health fairs to refer children for immunization. About 365,000 children in Alameda County are in the immunization registry. The Perinatal Hepatitis B program encouraged vaccination of babies born to Hepatitis B positive women, provided care coordination, assisted contacts to obtain screening and provided technical assistance to providers about Hepatitis B vaccination programs.

c. Plan for the Coming Year
MCAH will be working with the Immunization Branch in its roll-out of the new adolescent immunizations over the next couple years. Many local MCAH programs plan to conduct outreach, such as, Health Fairs, where education and resources for childhood immunizations are provided and advance immunization registry activities such as Orange County's plan to link to the L.A. County Immunization Registry.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	20	20.1	20	19.7	19.4
Annual Indicator	20.3	20.0	19.9	19.1	19.1
Numerator	16740	17208	17582	17008	
Denominator	822674	858626	882026	888169	
Data Source				CA Birth Statistical Master File, 2008	CA Birth Statistical Master File
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	19.1	18.8	18.5	18.2	18.2

Notes - 2009
A manual indicator is reported for 2009 based on 2008.

Notes - 2008
Numerator: State of California, Department of Public Health, Center for Health Statistics, 2008 California Birth Statistical Master File. Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007. Tabulations were done by the MCAH Program.

Data for 2006-2008 should be not compared to data reported in previous years due to updates in the 2000-2050 population projections released by the California Department of Finance (July 2007). Rates for prior years using these updated population estimates: 2000 = 26.5; 2001 = 23.8; 2002 = 22.4; 2003 = 21.2; 2004 = 20.6; 2005 = 20.3

Notes - 2007
Numerator: State of California, Department of Public Health, Center for Health Statistics, 2007 California Birth Statistical Master File. Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007. Tabulations were done by the MCAH Program.

Data for 2006-2007 should be not compared to data reported in previous years due to recent updates in the 2000-2050 population projections released by the California Department of Finance (July 2007). Rates for prior years using these updated population estimates: 2000 = 26.5; 2001 = 23.8; 2002 = 22.4; 2003 = 21.2; 2004 = 20.6; 2005 = 20.3

a. Last Year's Accomplishments
The rate of births among 15-17 year old adolescents steadily decreased from 26.6 per 1000 in 2000 to a record low of 19.1 per 1000 in 2008. For 2008, Hispanic teens continue to have the highest birth rate at 32.3. African-American teens had the second highest birth rate at 19.7, followed by Native American, 13.3 Pacific Islander, 10.2; White, 5.0, and Asian, 4.5. Teens who reported multiple races had a birth rate of 13.5 in 2008.

California conducts numerous activities and programs to reduce teen births. In OFP, programs include the Family Planning, Access, Care, and Treatment Program (Family PACT); the Community Challenge Grant (CCG); and the Information and Education Program (I&E). California's 2009 Budget Act eliminated the Teen Smart Outreach and the Male Involvement Program in September 2008. Family PACT provides family planning services to eligible low income men and women, including teens. CCG is a wide-scale, community-driven teen pregnancy prevention program that utilizes a variety of approaches and strategies to reduce teenage and unintended pregnancy and absentee fatherhood, promote responsible parenting, and increase the involvement of fathers in the economic, social, and emotional development of their children. I&E provides services to youth and adults throughout the state in a variety of settings using various strategies appropriate to meeting the growing and diverse needs of Californians today. The program provides funding for educational programs that emphasize primary prevention to enhance knowledge, attitudes and skills of adolescents and young men and women of childbearing age to make responsible decisions relevant to sexual and reproductive behavior.

AFLP utilizes a case management and mentoring model to assess and address the risks and resources of adolescent clients related to pregnancy prevention, birth outcomes, access to health insurance, appropriate utilization of health care, and to enhance the psychosocial and economic well-being of the adolescent family. AFLP served 11,320 teens in FY 08/09.

DSS operated the Cal-Learn program, which assists pregnant and parenting teens to attend and graduate from high school, reduce repeat pregnancies, and provides case management services according to AFLP standards. CDE funded 140 school districts and county offices of education to operate the California School Age Families Education (Cal-SAFE) program. Cal-SAFE is designed to increase the availability of support services necessary for enrolled

expectant/parenting students to improve academic achievement and parenting skills and reduce repeat pregnancy. This program served 12,425 students in 08/09 despite a 15% budget cut in 145 agencies.

In May 2009, PHCC launched its official website: www.everywomancalifornia.org. The website aims to reach consumers and providers with preconception health information and resources, including links to resources such as reproductive life planning toolkits and other materials relevant to teens. MCAH also received a First Time Motherhood grant from HRSA/MCHB to test "preconception health" and "reproductive life planning" in specific populations at risk for unplanned pregnancy and poor birth outcomes, including youth of color.

Every 3 years, MCAH enters into a contract with CAHC to address the most current adolescent health concerns. CAHC created an extensive statewide Hot Spot Needs Assessment and provided administrative and technical support to ASHWG, which is a collaborative of public health and education professionals who address sexual and reproductive health needs of youth. ASHWG posted integrated State-level reproductive health data tables including STD, Human Immunodeficiency Virus (HIV) and adolescent birth data for 2000-2008 to the MCAH website, as well as the website of CAHC. ASHWG also completed core competencies for providers of adolescent sexual and reproductive health. This information is posted on the CAHC website.

MCAH also completed a Teen Birth Rate Resource, which includes detailed maps and tables of teen birth rates by race/ethnicity at sub-county levels, for targeting of teen pregnancy prevention efforts.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. AFLP provides case management services to pregnant and/or parenting teens to improve birth outcomes and prevent additional pregnancies.		X		
2. The Family PACT Program provides reproductive health services, education, and counseling to 300,000 adolescents annually, including comprehensive clinical exams and access to contraception.	X			
3. The Community Challenge Grant Program funds 116 community agencies.		X		
4. Cal-SAFE, operating in 137 school districts, enables expectant/parenting adolescents to improve academic achievement and parenting skills, and provides quality child care/developmental programs.			X	
5. MCAH, OFP, Office of AIDS, and the Sexually Transmitted Disease Branch collaborate with key stakeholders at the state level, to better coordinate efforts in HIV, STD, and teen pregnancy prevention.				X
6. MCAH, OFP and key stakeholders collaborate on data integration to generate STD, HIV, and birth data for 2000-2004.				X
7. MCAH, OFP and key stakeholders collaborate on Core Competencies, a document intended as an interdisciplinary guide for staff and professionals who work on adolescent sexual health issues.				X
8. The Teen SMART Outreach program funded 21 agencies through September 2008.		X		

9. The Male Involvement Program funded 21 agencies through September 2008		X		
10. The Information & Education program funded 27 agencies in 2008.		X		

b. Current Activities
OFP, Family PACT, CCG and I&E continue their teen pregnancy prevention efforts. However, current budget reductions resulted in less program evaluation, education, and outreach for teen pregnancy prevention programs.

AFLP lost $10.7 million in state funding in state FY 2009/2010 resulting in nearly 6500 fewer clients; currently, there are 4963 clients enrolled.. Additional clients are served with local funding obtained from other sources. Cal-Learn is projected to serve 10,359 teens. Cal-SAFE has enrolled 13,000 students as of November 2009. CalSAFE had an additional 5% budget cut and 137 agencies are now participating.

PHCC received national attention and was presented at the Teen Now conference in September 2009. In October 2009, MCAH sponsored focus groups through local Title X clinics to explore the concepts of preconception health and reproductive life planning. Four groups were composed of teens providing feedback about the language and message delivery strategies suited for a teen audience.

MCAH is working with the Internet Sexuality Information Services to develop the youth component of the First Time Motherhood grant.

CAHC is refining the Hot Spot needs assessment; piloted a needs assessment in 3 LHJs; provided a behavioral health train the trainer; and a legal workshop for foster youth providers. ASHWG developed a 5-year strategic plan that also addresses teen pregnancy through 3 strategic areas: core competencies, data integration, and youth development.

c. Plan for the Coming Year
OFP will continue to fund CCG and I&E projects and will release Requests for Applications (RFAs). CCG RFAs will require evidence based curricula; rigorous program evaluation and comprehensive medically accurate sex education in accordance with California law. The I&E program design will integrate outreach strategies previously funded under Teen Smart Outreach. MCAH will continue the AFLP. Some counties may lose their funding from other sources. MCAH is exploring new federal grants for teen pregnancy prevention to expand AFLP services. Cal-SAFE will continue serving students. Some agencies may close or decrease their programs, since it is a categorical program and agencies have full flexibility in using funds. Cal-Learn is projected to serve 12,285 clients in FY 10/11. PHCC will implement and evaluate the youth preconception social marketing campaign, and will offer more opportunities to integrate culturally appropriate tools and resources into existing programs addressing teen reproductive health. The PHCC plans to further develop the EveryWomanCalifornia website with more teen-friendly features, including interactive reproductive life planning tools and health quizzes. CAHC will provide technical assistance and data reports to local communities and LHJs to build capacity and engage communities and youth in adolescent health activities. ASHWG will implement a new strategic plan through three subcommittees including: youth development, data integration, and core competencies.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	31	27.6	27.6	28.1	28.6
Annual Indicator	27.6	27.6	27.6	27.6	27.6
Numerator	130064	129152	128373	129671	
Denominator	471246	467943	465121	469824	
Data Source				Dental Health Foundation, 2006	Dental Health Foundation
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	29.1	29.6	30.1	30.1	30.1

Notes - 2009
A manual indicator is reported for 2009 based on 2008

Notes - 2008
Data source for percent of third grade children with sealants: Dental Health Foundation, California Smile Survey, "Mommy It Hurts to Chew," February 2006. Accessed 10/02/08 at http://www.dentalhealthfoundation.org/images/lib_PDF/dhf_2006_report.pdf.

*Based on weighted results from a completed survey of a representative sample of elementary schools in California conducted during 2004-05. Dental sealant information is based on one-minute, non-invasive oral health screening of all third graders in selected schools using protocols from the Association of State and Terroitorial Dental Directors at http://www.dentalhealthfoundation.org/index.php?option=com_content&task=view&id=43&Itemid=60. Accessed 10/02/08.

Denominator source: California Department of Education. Accessed 09/01/09 at http://dq.cde.ca.gov/dataquest/StateEnr.asp?cChoice=StEnrGrd&cYear=2008-09&cLevel=State&cTopic=Enrollment&myTimeFrame=S&submit1=Submit

Notes - 2007
Data source for percent of third grade children with sealants: Dental Health Foundation, California Smile Survey, "Mommy It Hurts to Chew," February 2006. Accessed 10/02/08 at http://www.dentalhealthfoundation.org/images/lib_PDF/dhf_2006_report.pdf. *Based on weighted results from a completed survey of a representative sample of elementary schools in California conducted during 2004-05. Dental sealant information is based on one-minute, non-invasive oral health screening of all third graders in selected schools using protocols from the Association of State and Terroitorial Dental Directors at http://www.dentalhealthfoundation.org/index.php?option=com_content&task=view&id=43&Itemid=60. Accessed 10/02/08.

Denominator source: California Department of Education. Accessed 10/02/08 at http://dq.cde.ca.gov/dataquest/StateEnr.asp?cChoice=StEnrGrd&cYear=2007-

08&cLevel=State&cTopic=Enrollment&myTimeFrame=S&submit1=Submit. Numerators are estimates derived by multiplying the percent of children with a sealant by the denominator.

a. Last Year's Accomplishments
Children's access to preventive dental services is assessed in relation to the percent of third grade children who have received protective sealants on at least one permanent molar tooth. The percent with sealant in California is estimated to be 27.6 percent since 2005 since no new survey has been implemented to update this rate. The Healthy People 2010 objective is 50 percent.

The numerator for this performance measure is from the Oral Health Needs Assessment a survey of a representative sample of elementary schools in California in 2007-2008. Dental sealant information is based on a one-minute, non-invasive oral health screening of all third graders in selected schools. The California Office of Oral Health (OOH) partnered with MCAH and the Dental Health Foundation (DHF) to conduct the Oral Health Needs Assessment.

OOH directed the California Children's Dental Disease Prevention Program (CCDDP), which served about 300,000 preschool and elementary school children annually. CCDDP provided screening and application of dental sealants to children in grades 2-5 as well as other oral health activities. Last year, 14,013 children enrolled in this program received dental sealants. However, due to state budget cuts that were mandated July 2009, all state funding supporting this program was suspended indefinitely. It is estimated that half of the original contractors are continuing another year with modified or reduced services supported by funding from local sources.
I
In partnership with CCDDP and the UCSF School of Dentistry, Sierra Health Foundation's BRIGHTSMILES Program awarded up to $1 million in grants over a 3 year period to 4 new and 5 existing CCDDP school-based oral health preventive service programs. Beginning July, 2009, these programs entered their last year of funding and continue to follow the CCDDP model of screening, preventive treatment and education for more than 10,515 children per year. Last year, 1554 students received sealants.

To meet the demand for technical assistance at both the state and local levels, MCAH contracts with UCSF School of Dentistry for a dental hygienist to serve as the MCAH Oral Health Policy Consultant. MCAH, CMS, Medi-Cal and OOH are members of the California Oral Health Access Council (OHAC). OHAC is a diverse panel of stakeholders that are working together to improve the oral health status of the state's traditionally underserved populations. MCAH, CMS, Medi-Cal and OOH are also members of the Oral Health Workgroup. The Workgroup assists in the coordination of state oral health activities and serves as a clearinghouse for member organizations. In addition, MCAH, OOH and Medi-Cal are liaisons to the CHDP State Dental Subcommittee whose goal is to increase access to dental care for the CHDP eligible population.

In 2007 California law required that children receive a dental check-up within the last 12 months and up to May 31 of their first year in public school (kindergarten or first grade). Because of state budget cuts, schools are encouraged to continue to collect and submit data but are no longer mandated to do so.

DHF was awarded a HRSA "Targeted State MCH Oral Health Service Systems" four-year grant. The program provides screening, health education, fluoride varnish and dental referral resources to WIC families. MCAH joined the project advisory committee which provides technical assistance. Sites in 13 counties have been selected across the state with additional funding provided by First 5 LA and Kaiser Southern California.

As a member of another advisory committee, MCAH participated in the Perinatal Oral Health Consensus Conference to review literature and consider recommendations prior to creating state clinical oral health guidelines for providers who treat clients during pregnancy and early childhood.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Medi-Cal and HF provide access to a comprehensive package of primary and preventive services, including dental care, for California's low-income children.		X		
2. CHDP provides dental screenings for over 1.8 million children a year and is developing an Oral Health for Infants and Toddlers Provider Training Manual for county programs		X		
3. CMS Branch is undertaking activities to encourage orthodontists and dentists to accept more CCS children into their practices, including more rapid reimbursement.		X		
4. CCDDP provides dental sealants screening/application to more than 300,000 school children and oral health education in the classroom. CCDDP includes a parent education component.		X		
5. MCAH Program, with key State stakeholders (e.g. Medi-Cal, State First 5 Commission, CMS and APP), develops and promotes policy strategies that will improve the oral health of its targeted population.				X
6. MCAH Program has contracted with UCSF School of Dentistry for a dental hygienist to serve as the Branch's oral health policy consultant to provide technical assistance at the state and local levels.				X
7. Children are required to receive a dental check-up within 12 months of their enrollment into kindergarten or first grade, whichever is their first year of public school.				X
8. LHJs are working with medical, dental and education providers in community dental health advisory boards to promote preventive oral health practices and provide fluoride varnish applications.				X
9. Sierra Health Foundation, in partnership with CCDDP and UCSF, is awarding $1 million in grants over 3 years to new and existing CCDDP school-based oral health preventive service programs.				X
10. DHF was awarded a HRSA "Targeted State MCH Oral Health Service Systems" four-year grant. to link WIC families with oral health resources and services.				X

b. Current Activities

MCAH continues to meet with key state stakeholders to develop and promote policy strategies to improve the oral health of its targeted population. Oral health educational components have been added or revised in the CPSP "Steps to Take" Guidelines, BIH perinatal and postpartum curriculums, AFLP "Infant Feeding" Guidelines and CDAPP's Sweet Success Guidelines.

Eleven LHJs have a dental coordinator on staff. Other LHJs rely on collaboration with local oral health task forces to integrate oral health outreach programs and fluoride varnish clinics to serve MCAH target populations. MCAH case management programs, such as CPSP, BIH and AFLP, enroll women and their families into Medi-Cal and Healthy Families and provide them with necessary dental referrals. However, dental providers are difficult to find in many locations because few will accept public insurance or agree to treat low-income pregnant women.

With sponsorship from California Dental Association Foundation and ACOG, state perinatal clinical oral health guidelines have been created for providers engaged in the care of pregnant

women and their children. MCAH submitted recommendations during stakeholder review of the guidelines and has actively disseminated the report and its accompanying policy brief comments and it is hoped these guidelines will encourage more dental providers to treat their pregnant patients and young families.

c. Plan for the Coming Year

State and county programs will continue to promote oral health, but will not be able to fully address NPM 09 until appropriate funds are allocated for sealant promotion, placement, and continuous surveillance of prevalence.

MCAH will encourage LHJs to strengthen strategies to increase the number of children receiving preventive dental services. MCAH is developing oral health indicators to measure results of jurisdiction activities and will update and integrate oral health educational components into MCAH program guidelines and curriculums.

The MCAH Oral Health consultant will provide technical assistance to LHJs, including presentations, resources and links to grant funding. Oral health educational materials (in English and Spanish) that address early childhood dental decay prevention for mothers and young children will be distributed through MCAH programs. MCAH will promote and disseminate the California perinatal clinical oral health guidelines to assist health care professionals deliver oral health services to pregnant women and their children.

New state legislation will extend the functions of a registered dental assistant to place sealants under the direct supervision of a dentist or dental hygienist as well as perform oral health assessments in a school-based, community health setting. Additional legislation will allow anybody to apply topical fluoride under the prescription and protocol set by a physician or dentist to another person within a public health setting. Utilizing dental auxiliaries and lay personnel in this capacity may help more children receive preventive dental services.

As a result of the low prevalence of sealant use, the California Dental Association will be promoting a policy statement to encourage broader use of sealants by its members. A policy letter regarding sealants is also being created by the CHDP State Dental Subcommittee to encourage referrals by physicians to dentists.

DHF is producing an on-line guidebook to aid new WIC and oral health programs create alliances to bring preventive dental services to young WIC clients. DHF is providing examples of model programs that were developed in the earlier grant project along with other materials, such as sustainability suggestions. Promotion of these programs by MCAH and other oral health partners will increase access to those children most in need of services.

The American Academy of Pediatric Dentistry and the Office of Head Start have begun a five-year initiative to provide quality dental homes for Head Start and Early Head Start children. MCAH will participate in the California Leadership Advisory Team to provide strategic input on issues concerning project implementation, resource development, monitoring progress and other activities.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and	2005	2006	2007	2008	2009

Performance Data					
Annual Performance Objective	2.9	3	3.1	3	2.9
Annual Indicator	3.2	2.6	2.3	1.7	1.7
Numerator	257	218	191	143	
Denominator	7930829	8228513	8200066	8184698	
Data Source				CA Death Statistical Master File 2008	CA Death Statistical Master File
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	2.9	2.8	2.7	2.6	2.6

Notes - 2009
A manual indicator is reported for 2009 based on 2008.

Notes - 2008
Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2008 California Death Statistical Master File [The ICD-10 codes for fatal MV traffic injuries are: V30-V79(.4-.9), V81.1, V82.1, V83-V86(.0-.3), V20-V28(.3-.9), V29(.4-.9), V12-V14 (.3-.9), V19(.4-.6), V02-V04 (.1,.9), V09.2, V80(.3-.5), V87(.0-.8), V89.2].

Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California. July 2007. Tabulations (by place of residence) were done by the MCAH Program.

Data for 2007-2008 should be not compared to data reported in previous years due to changes in methodology used for calculating this indicator. The methodology was updated for consistency between fatal and nonfatal injury reporting. The rate now includes only motor vehicle traffic incidents and excludes motor vehicle non-traffic incidents. Rates for prior years using these updated inclusion criteria: 2000 = 2.6; 2001 = 2.7; 2002 = 2.6; 2003 = 3.2; 2004 = 2.7; 2005 = 2.8; 2006 =2.4.

Notes - 2007
Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2008 California Death Statistical Master File [The ICD-10 codes for fatal MV traffic injuries are: V30-V79(.4-.9), V81.1, V82.1, V83-V86(.0-.3), V20-V28(.3-.9), V29(.4-.9), V12-V14 (.3-.9), V19(.4-.6), V02-V04 (.1,.9), V09.2, V80(.3-.5), V87(.0-.8), V89.2]. Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California. July 2007. Tabulations (by place of residence) were done by the MCAH Program.

Data for 2007 should be not compared to data reported in previous years due to changes in methodology used for calculating this indicator. The methodology was updated for consistency between fatal and nonfatal injury reporting. The rate now includes only motor vehicle traffic

incidents and excludes motor vehicle non-traffic incidents. Rates for prior years using these updated inclusion criteria: 2000 = 2.6; 2001 = 2.7; 2002 = 2.6; 2003 = 3.2; 2004 = 2.7; 2005 = 2.8; 2006 =2.4.

a. Last Year's Accomplishments

The motor vehicle death rate for children 0-14 has been generally decreasing, with 2008 representing the lowest rate at 1.7 deaths per 100,000. Although the 2007 rate reflects a change in methodology used to calculate this indicator, this downward trend persists after adjustment of prior year rates. (See 2007 Notes.)

Rates for African American children, at 2.8 per 100,000, were twice as high as those for Asians (1.4 per 100,000) and Whites (1.1 per 100,000). Hispanics had a rate of 1.9 per 100,000. Other race/ethnic groups had too few deaths due to motor vehicle accidents to be included in the comparison.

CIPPP at SDSU is a resource center that provided technical assistance to state agencies and 14 LHJs, including regular reviews of the current injury prevention literature and maintains a resource library.

The Safe and Active Communities (SAC) Branch is the focal point for CDPH's injury prevention efforts and its activities include surveillance, planning and consensus building, interventions, policy development, professional education and training, and public information. SAC's California's Vehicle Occupant Safety Program (VOSP) coordinates Child Passenger Safety (CPS) efforts across California by creating partnerships that link state and local policy, enforcement, and educational efforts. VOSP supports CPS programs through programmatic and technical support, educational resources, data, and funding of CPS technician trainings. SAC oversees and administers the portion of the Child Health and Safety Funds reserved for unintentional childhood injury prevention. The state raises revenue to support child injury and abuse prevention programs by selling personalized auto license plates, called "Kid's Plates." Programs funded include bicycle safety, motor vehicle occupant protection, and pedestrian safety, child injury and abuse prevention programs and technical assistance to foster regional and local injury prevention efforts. SAC Medical Crash Outcomes Data links crash and medical records to document how "crash" circumstances affect medical outcomes. SAC completed its data linkage model and designed a web query system for improved traffic injury data. SAC is completing the implementation of the Strategic Highway Safety Plan, including some specifics to young drivers. SAC participates in meetings of the Statewide Committee on Traffic Safety (SCOTS), a task force with representatives from state and national agencies, including the CHP, , the California Office of Traffic Safety (OTS), the California Alcohol and Beverage Control, CDE and the California Department of Transportation. SCOTS develops and promotes strategies for reducing traffic injuries.

OTS funded the "Next Generation Click It or Ticket" campaign and awarded mini-grants during 2008-2009 with the goal of increasing seatbelt use statewide to 95% in 2009. In 2009, it awarded $82 million to 203 primary grantees for education and enforcement of the State's driving under the influence (DUI) laws, including increased sobriety checkpoints, DUI patrols, warrant service operations for multiple DUI offenders and a variety of programs for California high schools and enforcement.

LHJs conducted child injury prevention activities. For example, Humboldt County conducted a "Gift of Safety" radio campaign designed to raise awareness about childhood injury prevention. The campaign encouraged the purchase of safety equipment during the 2008 holiday season. San Diego County developed a low literacy curriculum covering health and safety information from pregnancy through age 3 years, which was tailored for use during home visits. AFLP, CPSP, and BIH provided educational materials on use of car seats and child injury prevention instruction. Some LHJs received grants from the OTS which enabled them to expand childhood injury prevention programs.

There are 13 local Safe Kids coalitions that bring together health and safety experts, educators, foundations, corporate sponsors, government agencies and volunteers to identify and target the injury problems most prevalent in their local areas. Other activities California has undertaken to reduce motor vehicle deaths among children include: increased enforcement of drinking and driving laws; passenger restraint laws; graduated driver licensing; public education campaigns addressing the risks of drinking while driving; and vehicle safety improvements.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. LHJs participate in the SAFE KIDS Coalitions to implement traffic safety training, child passenger safety checks and safety seat distribution, and bicycle helmet education programs.		X	X	X
2. AFLP, BIH, and CPSP provide educational materials on use of car seats and child injury prevention.		X		
3. To raise funds to support child injury and abuse prevention programs, the State sells special car license plates, called Kid's Plates.				X
4. SAC maintains an up-to-date list of locally operated child passenger safety seat programs for use by traffic courts, community agencies, hospitals and clinics.		X		
5. CIPPP builds state and local capacity for injury prevention by providing technical assistance to state agencies and LHJs, including regular reviews of the current injury prevention literature.				X
6. OTS funds" Click It or Ticket "campaigns.			X	
7. SAC runs Vehicle Occupant Safety Program and the SCOTS program.			X	X
8. CIPPP provides technical assistance to LHJs				X
9. OTS maintains a Facebook page to discourage drunk driving and share other information on traffic safety.			X	
10. OTS measures safety seat usage.			X	X

b. Current Activities

CIPPP conducted a "Moving Children Safely" conference in March 2010 to promote awareness, communication, and collaboration among public health and other professionals committed to ensuring child safety. Subjects include innovative ways to improve traffic environments, and programs to promote safety for young pedestrians, bicyclists, and motor vehicle occupants (ages 0 to 18) and teen driver and child passenger safety. LHJs participate in Safe Kids Coalitions, child passenger safety checks, child passenger safety seat distribution and training, and bicycle helmet educational programs.

SAC continues its efforts to reach children, ages 0-16 and evaluate child transporters in state-sponsored social services programs, expand multiple cause of death database, involve partners in analysis, develop and implement action items in the Strategic Highway Safety Plan, and participate in SCOTS.

OTS updated its Traffic Safety Report Card that showed that child safety seat usage is at 91% in 2009. Passenger vehicle case fatalities for children ages 0-8 decreased 50% from 84 cases in 2007 to 42 cases in 2008. OTS created a Facebook page in December 2009 to share information on traffic safety, focusing on discouraging drunk driving, distracted driving, safe driving in stormy conditions, and publicized that traffic fatalities for 2009 reached a record low. MCAH continues to

seek opportunities to collaborate with the above initiatives to decrease motor vehicle deaths.

c. Plan for the Coming Year
The current activities of MCAH, CIPPP and LHJs will continue as resources allow. LHJs continue to face funding challenges, and will address motor vehicle safety as part of their overall strategies to address causes of childhood injuries. MCAH LHJs have identified unintentional injuries as priorities. MCAH will continue to seek opportunities to collaborate with SAC. MCAH will maintain awareness of the SCOTS coalition statewide goals and priorities; strengthen injury prevention and control partnerships; share data, knowledge and resources; avoid redundant activities; and leverage existing resources, including funds, people and leadership attention, toward common objectives.

SAC will expand current outreach efforts to include all transporters of children between the ages of 0-16 and expand outreach efforts with special needs children, transporters and caregivers. The Medical Crash Outcomes Data collection will end unless it receives more funding. SAC will continue to develop and implement phase II action items in the Strategic Highway Safety Plan and participate in SCOTS.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		69.6	71	71.5	72
Annual Indicator	70.2	69.4	61.6	59.9	60
Numerator	369404	377112	260565	227520	
Denominator	526361	543134	423075	379768	
Data Source				MIHA, 2008	MIHA
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	65	65	65	65	65

Notes - 2009
A manual indicator is reported for 2009 based on 2008.

Notes - 2008
Source: 2008 Maternal and Infant Health Assessment Survey (MIHA), MCAH Program, California Department of Public Health. Numerator: The number of women who delivered a live birth and who reported any breastfeeding at 3 months of age. Denominator: The number of women who delivered a live birth that reported whether or not they breastfed at 3 months of age. Numerator and denominator are weighted to the representative number of resident women in the state who delivered a live birth that year and exclude mothers who could not answer the question because

they responded to the survey before 3 months post-partum.

Data for 2007-2008 should not be compared to prior years due to changes in the MIHA survey. The MIHA breastfeeding question changed to breastfeeding at 3 months, compared to breastfeeding at 2 months in 2006 and prior years.

Notes - 2007
Source: 2007 Maternal and Infant Health Assessment Survey (MIHA), MCAH Program, California Department of Public Health. Numerator: The number of women who delivered a live birth and who reported any breastfeeding at 3 months of age. Denominator: The number of women who delivered a live birth that reported whether or not they breastfed at 3 months of age. Numerator and denominator are weighted to the representative number of resident women in the state who delivered a live birth that year and exclude mothers who could not answer the question because they responded to the survey before 3 months post-partum.

Data for 2007 should not be compared to prior years due to changes in the MIHA survey. The MIHA breastfeeding question changed to breastfeeding at 3 months, compared to breastfeeding at 2 months in 2006 and prior years.

a. Last Year's Accomplishments
Performance Measure 11 was revised in 2006 from the percentage of mothers who breastfeed their infants at hospital discharge to the percentage of mothers who breastfeed their infants at six months of age. Data on breastfeeding at age six months are currently not available for California. The closest currently available data are for breastfeeding at three months of age; these were first collected in 2007. Prior to 2007, the closest available data were for breastfeeding at two months of age. Data for this measure cannot be compared across years. In 2008, 59.9 percent of mothers breastfed their infants at 3 months of age.

MCAH refined and expanded the BBC Project to provide technical assistance and training to hospitals in areas of California with the lowest exclusive breastfeeding rates. Hospital administrators in the Central Valley, Orange County and L.A. County were educated about the ways they can improve their policies and procedures. BBC provided technical assistance to hospital staff at labor and delivery hospitals using the hospital breastfeeding toolkit to improve hospital lactation policies, including the use of quality assurance indicators. Staff education and training was provided free of charge, and networking opportunities were offered.

MCAH continued to be involved with strategic planning of the CDC-funded California Obesity Prevention Initiative (COPI) entitled Nutrition, Physical Activity and Obesity Prevention Program (PAOPP). MCAH is part of the breastfeeding strategic planning for this grant. In spring 2009, a temporary Breastfeeding Roundtable was formed to replace the previous Breastfeeding Promotion Advisory Committee. This provisional group helped author the first draft of the California breastfeeding strategic plan.

MCAH worked with the Nutrition, PAOPP and WIC to develop policies to support breastfeeding among CDPH staff, develop educational materials to support these policies, and improve signage for existing lactation rooms within department buildings. MCAH continued to refine MIHA breastfeeding questions to obtain more useful data for targeting hospital interventions. MCAH continued to improve the CDPH and MCAH breastfeeding web pages to make them more useful to the consumer and local MCAH programs.

MCAH provided technical assistance to other partners, such as Medi-Cal, the United States Breastfeeding subcommittee, and the California Obesity conference. MCAH co-sponsored the California Breastfeeding Awareness Walk on October 15, 2008. The majority of the MCAH LHJs reported that they support breastfeeding via their Title V allocation funding. MCAH programs such as CPSP, AFLP, BIH, and CDAPP continued to promote exclusive breastfeeding among their constituencies. MCAH showcased breastfeeding initiatives at the California Childhood Obesity

Conference in June 2009.

MCAH participated on a workgroup to develop a maternal health Medi-Cal Dashboard. Exclusive breastfeeding of term births at hospital discharge was chosen as a key postnatal measure.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. AFLP promotes breastfeeding among adolescent mothers, an age group that is less likely to breastfeed.		X		
2. CDAPP promotes breastfeeding as beneficial for both mother and child in reducing the risk for diabetes.		X		
3. BIH collaborates with local breastfeeding coalitions to promote breastfeeding in several counties.		X		
4. CPSP promotes breastfeeding through nutrition assessment and counseling	X			
5. MCAH is participating on the CDPH Obesity Prevention Group as breastfeeding promotion is one of the interventions for childhood obesity prevention.				X
6. MCAH staff help promote local breastfeeding coalitions, including participating at the California Breastfeeding Coalition meetings.				X
7. MCAH is providing toolkits, training and technical assistance (via RPPC) to staff at labor and delivery hospitals to improve hospital lactation policies.		X		
8. MCAH maintains the CDPH and MCAH website's breastfeeding pages which includes information on advocacy groups, hospital-specific data on breastfeeding at hospital discharge, MCAH reports, model hospital breastfeeding policies, information on workplace				X
9.				
10.				

b. Current Activities

The MCAH nutrition and physical activity coordinator is a member of the US Breastfeeding Promotion Committee and is the Chair of the MCH Nutrition Council of the Association of State and Territorial Public Health Nutrition Directors. The Council addresses policy, programs and services including promoting nutrition wellbeing across the lifespan for women including breastfeeding.

Due to state budget cuts in August 2009, funds for BBC, were reduced. Funding continues for L.A. to develop a report on findings from the project and provide technical assistance for all RPPCs for 2 years. To date, 20 hospitals fully participated, though two of the funded regions have obtained other funds to continue their work.

MCAH is developing the fourth letter to labor and delivery hospital administrators with annual hospital breastfeeding rates, resources, and an offer of technical support through RPPC.

In December 2009, CDPH, the California Breastfeeding Coalition, and the California WIC Association began the California Breastfeeding Roundtable. The Roundtable meets for the second time in June 2010 and has drafted a strategic plan that will be used by the Nutrition, Physical Activity and Obesity Prevention grant funded by CDC.

MCAH has been assisting in the nutrition revisions of Caring for Our Children: National Health and Safety Standards: Guidelines for Out-of-Home Child Care Programs, with special attention to breastfeeding.

c. Plan for the Coming Year

BBC Curriculums and tools will be posted on the MCAH breastfeeding website. In response to California Senate Bill 22, WIC and MCAH will finalize a web-based curriculum for hospital administrators to move them toward the model hospital breastfeeding policies. MCAH will continue to monitor both the hospital exclusive and any breastfeeding rates and post them on their website. In addition, MCAH will refine the MIHA breastfeeding questions to obtain more useful data for targeting hospital interventions. MCAH will continue to improve the CDPH and MCAH breastfeeding web pages to make them more useful to the consumer and local MCAH programs. The nutrition and physical activity coordinator will continue as an active member of the U.S. Breastfeeding Committee Workplace and Marketing workgroups.

MCAH is collaborating with CDC to determine whether the level of implementation of any or all of the "Ten Steps to Successful Breastfeeding" of the Baby Friendly Hospital Initiative, measured by CDC's national Maternity Practices in Infant Nutrition and Care (mPINC) Survey, affects the percentage of women who initiate breastfeeding exclusively in California birthing hospitals. MCAH will assess regional differences in the implementation of policies that promote and support breastfeeding throughout California hospitals and disseminate regional benchmark reports. These reports will help facilities identify maternity care practices they can change to better support breastfeeding. In addition, results of this project will be highlighted at the Maternal and Child Health Epidemiology Conference and American Public Health Association (APHA) Conference in 2010.

MCAH is collaborating with WIC to coordinate the peer counseling project with the MCAH hospital breastfeeding QI initiatives to promote a curriculum of breastfeeding promotion and support from prenatal to the postpartum period including hospital stay.

MCAH will continue to share information with its programs during the annual World Breastfeeding Week (August 1-8). MCAH will e-mail all county and community based organizations encouraging their participation in the celebration.

Lactation technical assistance, guideline development and trainings will continue for CPSP, AFLP, RPPC, CDAPP and BIH.

MCAH will continue to promulgate previous initiatives, including finalizing pilot/demonstration projects and marketing a BBC Project Report to outline the model elements and provide lessons learned from implementing the project. MCAH will continue to be involved with the CDC-funded COPI entitled Nutrition, PAOPP.

MCAH will continue working with the Nutrition, Physical Activity and Obesity Prevention Program and WIC to develop policies to support breastfeeding among CDPH staff, develop educational materials to support these policies, and improve signage for existing lactation rooms.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and	2005	2006	2007	2008	2009

Performance Data					
Annual Performance Objective	70	75	75	85	95
Annual Indicator	75.0	75.7	73.3	93.2	93.2
Numerator	411162	425638	415867	515062	
Denominator	548216	562157	567527	552618	
Data Source				Office of Vital Records birth certificate data	Office of Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	95	95	95	95	95

Notes - 2009
Manual indicator is reported for 2009 based on 2008 results. 2009 data will be available in February 2011.

Notes - 2008
Measure based on hospitals carrying out universal newborn hearing screening in California. This measure is the percent of newborns who have been screened for hearing before hospital discharge.
Source: Numerator and denominator data are from the State of California, Department of Public Health, Office of Vital Records, birth certificate data. Numerator: Number of newborns who have been screened for hearing before discharge for FY 2008.
Denominator: Number of live births by occurrence in California in FY 2008.

Notes - 2007
Section Number: Performance Measure #12
Field Name: PM12
Row Name:
Column Name:
Year: 2007
Field Note:

Measure based on hospitals carrying out universal newborn hearing screening in California. This measure is the percent of newborns who have been screened for hearing before hospital discharge.
Source: Numerator and denominator data are from the State of California, Department of Public Health, Office of Vital Records, birth certificate data. Numerator: Number of newborns who have been screened for hearing before discharge for FY 2007.
Denominator: Number of live births by occurrence in California in FY 2007.

a. Last Year's Accomplishments

1) The CMS Branch awarded Neometrics a state contract to provide a statewide Data Management Service (DMS) in all NHSP certified hospitals for which implementation has already begun.

2) The CMS Branch collaborated with DDS to obtain Individualized Family Service Plan dates on infants in the NHSP on a quarterly basis.

3) The CMS Branch provided technical assistance and consultation support to Hearing Coordination Centers (HCCs) to ensure that all general acute care hospitals with licensed perinatal services provide hearing screening tests to all newborns in a manner consistent with NHSP standards and requirements.

4) Amended the HCC contracts to implement a 10% budget cut due to California's fiscal crisis.

5) Expansion activities were delayed and a new timeline for all 90 expansion hospitals to be certified was moved to December 31, 2009.

6) The CMS Branch justified the need for the data management service contract and received approval to move forward with contract execution and implementation.

7) The CMS Branch continued to facilitate the Quality Improvement learning collaborative.

8) The CMS Branch worked with CDE to implement a Memorandum of Understanding to share information between the HCCs and the MCHB-funded parent support contractors.

9) The CMS Branch worked with the Speech Language Pathology and Audiology licensing board regarding quality of care issues and standards of audiologic practice.

10) The CMS Branch worked with Medi-Cal and its fiscal intermediary to address issues affecting access to outpatient hearing, screening and audiology services.

11) The CMS Branch applied for a Teleaudiology Grant to pursue strategies for improving the quality of and access to audiology services and minimizing the shortage of pediatric audiology providers for Northern California.

12) The CMS Branch applied for and was awarded a CDC grant that supports non-Federal conferences that is specifically available to NHSPs. The purpose of the grant is to cover the costs related to planning and facilitating public health conferences. The anticipated date for the announcement of awardees is May 14, 2010.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CMS Branch will work with the California Department of Education to support the implementation of the parent support activities in the grant from MCHB.		X		
2. Activities to implement a statewide data management service for the NHSP will continue.				X
3. Technical assistance and consultation support will continue for all HCCs.		X		
4. CMS Branch will ensure that all general acute hospitals with licensed perinatal services will participate in the NHSP expansion.			X	
5. CMS Branch continues to work with Medi-Cal and its fiscal intermediary to address issues affecting access to outpatient hearing screening and audiology services.				X
6.				

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b. Current Activities

1) All general acute care hospitals with licensed perinatal services are being certified for participation in the NHSP.

2) The CMS Branch collaborates in the implementation of the parent support grant from MCHB.

3) Neometrics is preparing the DMS for the NHSP for its first online pilot test on a small sample group of certified hospitals.

4) The CMS Branch is an active participant in the NHSP QI learning collaborative.

5) The CMS Branch produces new issues of the Audiology Bulletin to address additional areas of interest to pediatric audiologists.

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6) The CMS Branch provides technical support to the HCCs.

7) The CMS Branch continues to collaborate with UC Davis Hospital on a joint memorandum of understanding. Once completed, the CMS Branch will administer the Teleaudiology Grant.

c. Plan for the Coming Year

1) The CMS Branch will finalize the certification of the remaining hospitals.

2) The CMS Branch will continue to collaborate in the implementation of the parent support grant from MCHB.

3) The DMS for NHSP will be fully implemented in all certified licensed perinatal hospitals by the end of 2010.

4) The CMS Branch will continue participation and facilitation of the NHSP QI learning collaborative.

5) Technical assistance and consultation support will continue for all HCCs to ensure compliance with NHSP standards and requirements.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	12.9	13	13.5	13.3	13.1
Annual Indicator	13.6	13.9	11.2	11.0	11
Numerator	1443896	1458592	1185414	1167278	
Denominator	10616890	10493468	10584055	10611615	
Data Source				Current Population	Current Population

				Survey, 2008	Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	12.9	12.7	12.7	12.5	12.5

Notes - 2009
A manual indicator is reported for 2009 based on 2008.

Notes - 2008
Source: Estimated percent of uninsured children (age 0-18) is from the Kaiser Family Foundation analysis of the March 2008 release of the Current Population Survey.

Denominator (estimate of the number of children 18 years of age and younger): State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007. The numerator was derived by multiplying the percent uninsured by the denominator.

Notes - 2007
Source: Estimated percent of uninsured children (age 0-18) is from the Kaiser Family Foundation analysis of the March 2008 release of the Current Population Survey. Denominator (estimate of the number of children 18 years of age and younger): State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007. The numerator was derived by multiplying the percent uninsured by the denominator.

a. Last Year's Accomplishments
The relative percent change in uninsured children in California has decreased 27.3 percent since 2000 when the percent of children without health insurance was 15.7 percent. After slight increases in 2005-06, the percent without insurance continued to decrease to 11.0 percent in 2008. Despite this success, over 1.1 million children still lack coverage. The Healthy People 2010 objective is zero percent uninsured.

Data for NPM 13 are based on the U.S. Current Population Survey. Estimates derived from the 2007 CHIS, which utilizes a different survey methodology, produce slightly lower numbers.[35] According to the 2007 CHIS, 1.1 million California children age 0 to 18 (10.2 percent) lacked health insurance coverage all or part of the year in 2007.[36]

Insurance coverage rates depend largely on four sources of coverage: job-based insurance, privately purchased insurance, Medi-Cal and HF. According to the 2007 CHIS, just over half of children aged 0-18 were covered by job-based health insurance, and less than a third were enrolled in Medi-Cal and HF. In addition, just over half of children aged 0-18 were covered by job-based health insurance, and less than a third were enrolled in California's Medi-Cal and HF.[37] Of California's uninsured children, 385,000 (56%) were eligible for enrollment in Medi-Cal or HF. Another 155,000 uninsured children were eligible for one of the 14 county-based Healthy

Kids programs in 2007, but not enrolled. The remaining 143,000 uninsured children were not eligible for these public programs due to family income, or because they lived in counties without a Healthy Kids expansion program.[37] California's number of uninsured children could be reduced 80 percent if all children eligible for public insurance programs were enrolled. In an effort to decrease the number of uninsured children, a comprehensive outreach and education campaign has been undertaken to increase enrollment in Medi-Cal and HF. Efforts to reduce administrative barriers include a shortened joint application for both Medi-Cal and HF, elimination of quarterly status reports under Medi-Cal, and on-line enrollment. Health-e-APP, a web-based HF application, became available in 2003 and has improved speed, accuracy, and consumer satisfaction with the application process.

Through the CHDP Gateway, any child under 19 years with family income at or below 200 percent FPL (and not already in the MEDS system) is "presumed eligible" for Medi-Cal or HF and given a temporary Medi-Cal Benefits Identification Card. This provides access to no-cost, full scope fee-for-service Medi-Cal benefits for up to 60 days. From July 2003 through December 2008, 3.9 million children were pre-enrolled in the Gateway, and 77 percent requested a joint application for Medi-Cal and HF. From June 2004 through December 2008, 285,027 infants were automatically enrolled in Medi-Cal, with 69,903 infants automatically enrolled as the result of a Gateway transaction in FY 2007-08.

Significant shares of the uninsured but eligible children are served by the Special Supplemental Nutrition Program for WIC. Senate Bill (SB) 437, enacted in October 2006, created the WIC Gateway. This allows parents and caretakers of infant and child WIC applicants to submit a simple electronic application to simultaneously obtain presumptive eligibility for Medi-Cal or HF and apply for enrollment to either as well.

Many counties have created Children's Health Initiatives (CHI) to locally fund insurance programs for children ineligible for Medi-Cal or HF coverage. California CHI is a collaboration of 29 local CHI's dedicated to ensuring that all California children have access to quality health coverage. Together, the CHI's emphasize streamlined enrollment into HF, Medi-Cal and Healthy Kids insurance programs, and share a goal of creating and maintaining a sustainable health care program for all children in California. Local MCAH programs assist families to enroll in available insurance programs, with 42 counties cumulatively reporting 47,394 referrals to Medi-Cal; 18,143 to HF; 554 to Access for Infants and Mothers (AIM); 40 to Healthy Kids; and 47,989 referrals to other insurance

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. MCAH programs and LHJs encourage and facilitate enrollment in Medi-Cal, HF, CHI and other low cost insurance programs via community outreach and education activities and local Toll-Free Telephone referral lines.			X	
2. CMS Branch works to maximize the effectiveness of the Gateway for enrolling eligible children in Medi-Cal or HF.				X
3. CHDP provides information and materials in multiple languages for the Gateway.				X
4. CDPH and MRMIB continue to implement and support improvements in the process of eligibility determination and enrollment for Medi-Cal and HF.		X		
5. DHCS and the WIC Program will conduct a feasibility study report over the next year to determine the viability of the WIC Gateway (established through legislation in 2006) and guide its development and implementation.				X

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b. Current Activities
MCAH programs, including AFLP, BIH, and CPSP, encourage and facilitate enrollment in Medi-Cal, HF and CHI. Efforts are ongoing and include public awareness media campaigns and other community education and outreach efforts. For example, Humboldt County implemented local systems changes to assure that infants born to mothers on Medi-Cal are immediately enrolled in Medi-Cal and to better track children accessing health care through the CHDP Gateway.

CDPH, DHCS and MRMIB, in collaboration with stakeholders, are responsible for designing, promulgating and implementing the WIC gateway to streamline and expedite health insurance enrollment for children served at local WIC agencies.

Local CHDP programs inform new providers about the Gateway and direct them to CHDP Gateway resources. The CMS Branch will continue to analyze CHDP Gateway data reports to monitor program operations and the needs of CHDP local programs and providers.

State funding for Certified Application Assistants (CAA) was terminated as of July 2003 due to the state budget crisis. Some CAAs continue working on a county-funded or volunteer basis, and the State continues to provide CAA trainings. CAAs work with families in clinics, community centers, schools, and homes, helping them navigate the complex eligibility structures of Medi-Cal and HF.

c. Plan for the Coming Year
MCAH programs, including AFLP, BIH, and CPSP, will continue to encourage and facilitate enrollment in Medi-Cal, HF and CHI through outreach, education and referral programs.

DHCS and MRMIB will continue to implement and support improvements in the process of determining eligibility and enrollment in Medi-Cal and HF.

MCAH LHJs will continue to provide outreach and referrals to health insurance plans for pregnant women, infants and families and provide supportive activities to ensure continuous access to recommended health care services. These activities may include identification of high risk populations, targeted outreach, provision of case finding and care coordination to women, children and adolescents who are not linked to a source of care. Other high risk groups targeted are children with special health care needs, low income pregnant women, and women of childbearing age who are at risk for adverse perinatal outcomes.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		33.7	33.6	33.6	33.5
Annual Indicator	33.7	33.2	33.6	33.3	33.3
Numerator	111876	112867	104896	100447	
Denominator	331975	339961	312190	301643	

Data Source				PedNSS, 2008	PedNSS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	33.5	33.4	33.4	33.4	33.4

Notes - 2009
A manual indicator is reported for 2009 based on 2008.

Notes - 2008
Data Source: CDC, Pediatric Nutrition Surveillance System (PedNSS) Annual Reports for Calendar Year 2008. Table 12C, 2008 Pediatric Nutrition Surveillance, Summary of Trends in Growth and Anemia Indicators, Children Aged < 5 years.

Overall percent computed by summing percent of children age 24-59 months in the 85th-<95th percentile for Body Mass Index (BMI) plus the percent greater than or equal to the 95th percentile for BMI. The numerator was calculated by multiplying the denominator by this overall percent. Data available at:
http://www.dhcs.ca.gov/services/chdp/Documents/PedNSS/2008/12C.pdf. Last accessed on September 1, 2009.

In California, PedNSS data are collected from the Child Health and Disability Prevention (CHDP) Program health assessment screening appointments. The CHDP program targets low-income, high-risk children, birth through 19 years of age. CHDP data are collected in medical offices/clinics and recorded on the CHDP Confidential Screening/Billing Report form (PM 160). This form is submitted for payment and program reporting as well as serving as California's data source. These data are transmitted to the CDC for inclusion in the national PedNSS.

Notes - 2007
Data Source: CDC, Pediatric Nutrition Surveillance System (PedNSS) Annual Reports for Calendar Year 2007. Table 16C, Growth Indicators by Race/Ethnicity and Age, 2007 Pediatric Nutrition Surveillance, California, Children Aged < 5 Years. Overall percent computed by summing percent of children age 24-59 months in the 85th-<95th percentile for Body Mass Index (BMI) plus the percent greater than or equal to the 95th percentile for BMI. The numerator was calculated by multiplying the denominator by this overall percent. Data available at:
http://www.dhcs.ca.gov/services/chdp/Documents/PedNSS/2007/16C.pdf. Last accessed on October 2, 2008.

In California, PedNSS data are collected from the Child Health and Disability Prevention (CHDP) Program health assessment screening appointments. The CHDP program targets low-income, high-risk children, birth through 19 years of age. CHDP data are collected in medical offices/clinics and recorded on the CHDP Confidential
Screening/Billing Report form (PM 160). This form is submitted for payment and program reporting as well as serving as California's data source. These data are transmitted to the CDC for inclusion in the national PedNSS.

a. Last Year's Accomplishments

California uses data gathered by PedNSS to report the percentage of children ages 2 to 5 years with a Body Mass Index at or above the 85th percentile. The rate dropped slightly from 33.6% in 2007 to 33.3%.in 2008.

MCAH's approaches to preventing overweight among children aged 2-5 years focus on modifying risk factors before pregnancy, in utero, and in infancy. MCAH promoted optimal preconception weight and euglycemia pre-pregnancy, optimal prenatal weight gain and glycemic control in pregnancy, and breastfeeding. These concepts were included in the strategic plan for addressing obesity in California. PHCC developed web-based fact sheets, links to resources, and best practices related to preconception health, such as healthy weight, healthy food choices and physical activity. MCAH worked on updating CDAPP nutrition and physical activity guidelines.

MCAH and CMS collaborate with the California Nutrition, PAOPP and the Champions for Change to promote healthy lifestyles to reduce the prevalence of obesity. MCAH and CMS participated on the 2009 Childhood Obesity Conference committee, which showcased evidence-based prevention interventions and community efforts. MCAH featured their BBC project, working with hospitals to integrate QI efforts within the maternity care setting to ensure policies and practices are supportive of breastfeeding, as well as the work they are doing to promote healthy weight before, during and after pregnancy, and "Tracking Childhood Obesity Trends Using Geographic Information System (GIS) Mapping, California: 1996-2006." MCAH was also on the planning committee for the 2009 Weight of the Nation, a national forum to highlight progress in the prevention and control of obesity through policy and environmental strategies. MCAH was instrumental in including a life course perspective and a presentation on BBC.

In June 2009, the MCAH Nutrition and Physical Activity Coordinator became Chair of the Association of State and Territorial Public Health Nutrition Directors' (ASTHPND) MCH Nutrition Council. The Council's goal is to achieve optimal health through healthy eating and active living among women, children and families and provide members with networking, educational and advocacy opportunities.

All MCAH LHJs worked on obesity prevention efforts. MCAH awarded the "Here is Where Healthy Starts" award for LHJs that had agency policies/programs in place to support good nutrition, physical activity, safety and breastfeeding.

CHDP collaborated with KP to co-brand a "Little Changes, Big Rewards" poster with evidence-based messages regarding childhood obesity. This poster was disseminated to local CHDP programs, CHDP providers and health plans for use as a provider prompt to deliver evidence-based counseling when obtaining BMI percentile during the CHDP health screen. The poster was used as a key tool in a counseling module that is made available for free to CHDP provider offices in an attempt to train providers about brief focused counseling.

CMS collected data and coordinated CDC's PedNSS in California. For 2008, children ages 2-5, overweight and obesity prevalence rates (based on BMI percentile) were16.0 % and 17.3 % respectively for a combined rate of 33.3%. For children and adolescents 5-20 years of age, overweight and obesity prevalence rates are18.3 % and 22.8 % respectively for a combined rate of 41.1%.

CMS worked with CDE, Child & Adult Care Food Program to utilize PedNSS factsheets as a performance measure and tool to educate over 70,000 child care providers about the prevalence of childhood obesity in their communities.

CMS continues to collect data from nutrition assessments by CHDP providers. State and local CHDP nutritionists develop and implement nutrition education, provide consultation and training to CHDP providers, and coordinate follow-up and referrals.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Data collection from CHDP nutrition assessments for the Pediatric Nutrition Surveillance System (PedNSS) continues.		X		
2. CHDP program benefits include cholesterol and fasting blood glucose screening tests for children at risk for obesity, the complications of obesity and at risk for cardiovascular disease.			X	
3. State and local CHDP nutritionists develop and implement nutrition education, provide consultation and training to CHDP providers, and coordinate follow-up and referrals to related programs.				X
4. MCAH develops and/or provides nutrition education materials and initiatives, nutrition assessment materials, technical assistance and consultation, and funding opportunities to MCAH programs and colleagues				X
5. BIH, AFLP, CDAPP and CPSP promote optimal weight gain in pregnancy, breastfeeding, and glycemic control as an effort to reduce the risk of obesity.		X		
6. MCAH partners with other state programs and agencies to dialogue with advocates, experts and local MCAH directors to prevent overweight among infants and pre-school aged children.				X
7. BIH, AFLP, CDAPP and CPSP promote physical activity and proper nutrition by encouraging healthy eating through discussions on how to cut fat, lower calories and move more.		X		
8. MCAH Offers MCAH LHJs a “Here is Where Healthy Starts” award for policies/programs in place to support good nutrition, physical activity, safety and breastfeeding.				X
9. MCAH and CMS collaborate with the California Nutrition Network for Healthy, Active Families to promote healthy eating and a physically active lifestyle among low income Californians.				X
10.				

b. Current Activities

MCAH and CMS continue to participate on the Obesity Prevention Group (OPG), which aims to integrate obesity prevention into CDPH programs and the California Nutrition, PAOPP,

MCAH provided technical assistance to LHJs to complete the American Recovery and Reinvestment Act: Communities Putting Prevention to Work state applications and continues to provide nutrition, physical activity, breastfeeding resources and intervention ideas to local LHJs.

PHCC Interconception Care Project of California in coordination with ACOG-CA and funded by MOD is finishing provider guidelines for the post-partum visit, which include interconception management of women who developed gestational diabetes during their prior pregnancy. MCAH is updating CDAPP, CPSP, BIH, and AFLP nutrition and physical activity guidelines and continuing with the revision of the adolescent cookbook. New nutrition assessment forms promoting the revised Institute of Medicine weight gain guidelines were finalized and posted on the MCAH website. MCAH continued to provide MCAH LHJs a "Here is Where Healthy Starts" awards.

CHDP continues to disseminate the "Little changes. Big rewards." poster to local CHDP programs, providers and health plans. CHDP collaboratively worked with the Office of Multicultural Health regarding the funding and dissemination of the poster in Spanish.

CMS collects data and coordinates PedNSS. Local CHDPs report on interpretation and use of PedNSS data for program planning.

c. Plan for the Coming Year

MCAH will continue to collaborate with other state programs and agencies to dialogue with advocates, experts and local MCAH directors to prevent overweight among our youngest, most vulnerable children. MCAH and CMS will continue to participate on OPG, which aims to integrate obesity prevention into CDPH programs, and develop an action plan and obesity-related proposals for funding opportunities.

MCAH will finalize a cookbook for teens. Options for substituting seasonal fruits and vegetables and recommendations for physical activity will be included as well as coordinate and provide information regarding recipe ingredients available through the new WIC food package. In addition, MCAH will update the Adolescent Nutrition and Physical Activity Guidelines for AFLP, BIH Guidelines, CDAPP Guidelines for Care, and the CPSP Steps to Take Guidelines. MCAH will continue to provide model nutrition, physical activity, breastfeeding resources and intervention to MCAH LHJ directors.

MCAH and CMS will work on the next Childhood Obesity Conference scheduled for 2011 in San Diego, California. Goals for the conference include:

1. MCAH and CMS will work on the next Childhood Obesity Conference scheduled for 20Promote collaboration among diverse stakeholders to ensure access to healthy foods and physical activity for all children.
2. Showcase evidenced-based prevention interventions to reduce overweight and obesity in high risk and low income communities.
3. Accelerate the obesity prevention movement to promote health equity and reduce disparities at the local, state and national levels.
4. Feature community efforts to implement environmental and policy strategies that promote and sustain healthy eating and activity behaviors.

CMS will continue to use PedNSS to identify population trends for childhood obesity and anemia. Local CHDP programs will respond to performance measures that assess their use of PedNSS as related to childhood obesity. Recently, the Physical Activity, Nutrition and Obesity Prevention Project requested PedNSS and CHDP data to assist with the Statewide Tracking and Evaluation System component of the California Obesity Prevention Plan.

Train the trainer workshops are currently offered to Medi-Cal Managed Care Health Plans and CHDP providers. These workshops train providers and office staff about the three provider skill sets involved with assessing and managing overweight children: BMI Screening, Using Brief Focused Advice and Clinical Follow-up and Use of Community Resources.

CHPCFC is planning a foster care nurse conference this year that addresses childhood obesity and systems of care. Foster care nurses have requested relevant tools and resources so they can better address this common health problem.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance	2005	2006	2007	2008	2009

Data					
Annual Performance Objective		3.4	3.7	3.6	3.5
Annual Indicator	3.8	3.0	2.6	3.3	3.3
Numerator	20218	16544	14706	18078	
Denominator	532721	555604	556252	542822	
Data Source				MIHA, 2008	MIHA
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	3.4	3.3	3.2	3.1	3.1

Notes - 2009
A manual indicator is reported for 2009 based on 2008.

Notes - 2008
Source: 2008 Maternal and Infant Health Assessment survey, MCAH Program, California Department of Public Health. Numerator: The number of women who delivered a live birth and who reported any smoking in the third trimester of pregnancy. Denominator: The number of women who delivered a live birth and reported whether or not they had smoked during their third trimester of pregnancy.

Numerator and denominator are weighted to the representative number of resident women in the state who delivered a live birth in 2008.

Notes - 2007
Source: 2007 Maternal and Infant Health Assessment Survey, MCAH Program, California Department of Public Health. Numerator: The number of women who delivered a live birth and who reported any smoking in the third trimester of pregnancy. Denominator: The number of women who delivered a live birth that reported whether or not they smoked during pregnancy. Numerator and deonominator are weighted to the representative number of resident women in the state who delivered a live birth that year.

a. Last Year's Accomplishments
In 2008, 3.3 percent of women 15 years of age and older who had a live birth reported smoking during the last trimester of pregnancy. Smoking during pregnancy has declined by 42 percent since 1999, when 5.7 percent of women reported smoking during the last three months of pregnancy. This is the first time since 1999 that the rate increased, an inconsistency with the continual decline in smoking among all women in California over the past two decades.

Smoking prevalence during the last trimester of pregnancy differs by race/ethnic group. For 2008, African-American women were most likely to smoke during the last trimester (9.7 percent), followed by White women (7.1 percent), Asian/ Pacific Islander women (1.5 percent), and Latinas (1.0 percent). The Healthy People 2010 target is that 99 percent of pregnant women not smoke during pregnancy.

Efforts to reduce and prevent smoking continued to be implemented in MCAH programs serving pregnant women. AFLP provided smoking exposure assessment and cessation assistance to pregnant teens. BIH provided referrals for treatment services for pregnant and/or parenting

African-American clients who used tobacco products. For women accessing prenatal care through Medi-Cal, CPSP included smoking cessation as one goal for improving maternal health and birth outcomes.

The California Tobacco Control Program supported statewide, county, and community smoking cessation projects. These projects worked in coordination with each other to create effective and innovative tobacco control interventions throughout California.

The California Smokers' Helpline provided intensive tobacco cessation counseling, which included tailored counseling services for teens, adults, pregnant women and chew-tobacco users. Perinatal Services Coordinators from LHJs have consulted with educational experts at the Helpline for outreach educational materials.

Smoking cessation is part of preconception care. It is one of the key components of the MCAH's PHHI and is critical to the work of PHCC. PHCC provides information, tools and resources to local communities focusing on the importance of achieving optimal health before pregnancy, including refraining from tobacco use. In May 2009, the PHCC launched a website (www.everywomancalifornia.org) which features low literacy fact sheets encouraging women (and their partners) to stop smoking in the event that they may have a baby in the future. The website also has tools and resources for providers such as successful models for integrating smoking cessation counseling into practice and links to the CDPH Tobacco Control Program's tobacco prevention efforts, the California Smokers Helpline and other smoking cessation programs.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. AFLP assess clients for smoking habits and exposure to second hand smoke and discuss the risks of smoking for the mother and baby during pregnancy and after birth.		X		
2. BIH clients receive education about smoking and health; the BIH Scope of Work includes smoking cessation to reduce low birth weights.		X		
3. CPSP guidelines assist providers and practitioners with health education, nutrition, and psychosocial intervention guidelines; handouts are also available, in English and Spanish, to educate women about smoking cessation.		X		
4. The California Tobacco Control Program supports statewide and local smoking cessation projects to create effective and innovative tobacco control interventions throughout California.		X		
5. The California Smokers' Helpline provides tailored counseling services for teens, adults, and pregnant women in English, Spanish, Korean, Mandarin, Cantonese, and Vietnamese.		X		
6. Diabetes educators throughout California have joined forces with the California Diabetes Program and the California Smokers' Helpline to assist the patients with diabetes quit smoking.				X
7. PHCC has developed a website with information for consumers and providers about health for women of reproductive age. It includes information about smoking during pregnancy and links to resources.				X
8. The Los Angeles Collaborative to Promote Preconception/Interconception Care is implementing systematic improvement for accessible perinatal healthcare and resources				X

over the next 2 years.				
9.				
10.				

b. Current Activities
AFLP clients are assessed at entry and annually for past and current smoking and exposure to second hand smoke. Case managers discuss the risks of smoking for the mother and baby during pregnancy and after birth.

BIH provides health education and health promotion related to smoking cessation in groups as well as case management for African-American pregnant and parenting women.

CPSP guidelines, "Steps to Take," assist providers and practitioners with health education, nutrition, and psychosocial interventions. "Camera ready" handouts, in English and Spanish, are available for CPSP to educate women about smoking cessation.

The California Tobacco Control Program funds projects that facilitate community norm change and provide infrastructure to support local tobacco control efforts. The California Smokers' Helpline provides intensive tobacco cessation counseling, which includes tailored counseling services for teens, adults, and pregnant women. CPSP coordinators consult with educational experts at the Helpline for resources and support services.

The L.A. Preconception Health Collaborative is working with the Tobacco Control Program and the South L.A. Area Health Officer to launch a smoking cessation project that will target the African American population. L.A.' MCAH has supported the project by identifying high risk areas and recruiting eligible African American mothers from various programs (BIH, Healthy Baby Learning Collaborative, L.A. Mommy and Baby, etc).

c. Plan for the Coming Year
AFLP, BIH, and CPSP will continue their activities related to smoking assessment, education, and cessation support for pregnant women. LHJs will continue their smoking cessation activities, including outreach, education, referrals, data collection, and data analysis.

The PHCC will continue to provide information, tools and resources to local communities focusing on the importance of achieving optimal health before pregnancy, including refraining from tobacco use.

The California Smokers' Helpline will continue to provide intensive tobacco cessation counseling via the telephone, and access to materials through its website. The California Tobacco Control Program will continue to provide technical assistance, resources, and/or services to the California tobacco control community. The California Diabetes Program will continue to join "Do You cAARd?" (Ask, Advise, Refer) campaign to help patients reduce their risk of complications and improve their health. The campaign includes a gold TAKE CHARGE card to be handed out to encourage use of the California Smokers Helpline.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009

Annual Performance Objective	4.8	5.6	4.7	4.7	4.6
Annual Indicator	4.9	5.2	4.1	4.4	4.4
Numerator	135	150	122	134	
Denominator	2762949	2865987	2955147	3019105	
Data Source				CA Death Statistical Master File, 2008	CA Death Statistical Master File
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	4.6	4.5	4.4	4.3	4.3

Notes - 2009
A manual indicator is reported for 2009 based on 2008.

Notes - 2008
Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2008 California Death Statistical Master File (ICD-10 Group Cause of Death Codes 331-337).

Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California. July 2007. Tabulations (by place of residence) were done by the MCAH Program.

Data for 2006-2008 should be not compared to data reported in previous years due to updates in the 2000-2050 population projections released by the California Department of Finance (July 2007). Rates for prior years using these updated population estimates: 2000 = 5.2; 2001 = 4.9; 2002 = 4.7; 2003 = 5.0; 2004 = 5.7; 2005 = 4.9

Notes - 2007
Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2007 California Death Statistical Master File (ICD-10 Group Cause of Death Codes 331-337). Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California. July 2007. Tabulations (by place of residence) were done by the MCAH Program.

Data for 2006-2007 should be not compared to data reported in previous years due to recent updates in the 2000-2050 population projections released by the California Department of Finance (July 2007). Rates for prior years using these updated population estimates: 2000 = 5.2; 2001 = 4.9; 2002 = 4.7; 2003 = 5.0; 2004 = 5.7; 2005 = 4.9

a. Last Year's Accomplishments
The rate of suicide deaths among California youth declined between 1990 and 1998, from 9.2 to 6.3 per 100,000 youth. Between 1999 and 2005, the rate fluctuated around 5.0. The rate was 5.2 in 2006 and 4.4 in 2008. The HP 2010 target is 5 per 100,000. DMH is the lead agency in

mental health in California. DMH continues to receive funding through the Mental Health Services Act (MHSA) of 2004, which imposes a one percent tax on annual incomes in excess of $1 million. 2008 was the first year that counties could submit their 3-year plans and begin to receive funding. A major focus of this funding is prevention and early intervention (PEI) in serious mental illness. Counties use 20% of their allocation for PEI. Fifty percent of resources must target people under the age of 25. DMH staff met monthly with 15 counties that have major suicide initiatives and with a consortium of 10 crisis centers to coordinate activities and build the network.

In July 2008 the Governor signed the Jason Flatt Act to help prevent youth suicide. The bill authorizes school districts to use a portion of their Professional Development Block Grant funding to pay for suicide prevention training for school teachers. On November 2008 the California State Library published Studies in the News, a service provided to DMH by the California State Library. This service features articles focusing on mental health issues, including youth suicide prevention. The SAC Branch maintains the California Electronic Violent Death Reporting System which records detailed data on suicide circumstances.

CIPPP continues to provide regional data (hospital discharges, fatalities) on youth self-harming behavior to LHJs, school districts and parent teacher organizations and distributed summaries of research on suicide and self-harm selected from journals of several fields (anthropology, behavioral sciences, civil engineering, criminology, medicine, nursing, social work, sociology, etc). CIPPP worked with California chapters of the AAP, the California Academy of Family Physicians, and members of the American Academy of Child and Adolescent Psychiatrists to provide summaries of recent research on the occurrence and prevention of child and adolescent self-harming behaviors. Staff of CIPPP serves on the ad hoc subcommittee on adolescent suicide prevention of the American Association of Suicidology.

MCAH plays an important role in identifying mental health needs, intervening before mental health problems become debilitating, and facilitating access to integrated, comprehensive treatment. A mental health component is included in CPSP, BIH, AFLP, CDAPP, PHHI and LHJ programs. All include assessment and/or referral, and some include treatment as well.

In 2008, CAHC sponsored the "Epidemic of Suicide of Adolescents and Young Adults" Workshop in Sacramento on August 4th with more than 100 participants. The CAHC website includes research information about adolescent suicide. Select LHJs received technical assistance from CAHC to do additional qualitative work in identified hot spots and consider best practice programs which have shown effectiveness in similar LHJs.

L.A. County MCAH programs identified adolescent well being as a local objective that includes teen suicide prevention. Interventions include a multidisciplinary collaborative planning process, website, and best practices workshop.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Center for Injury Prevention Policy and Practice (CIPPP) at San Diego State University is a resource center on child and adolescent injury prevention, including youth suicide.				X
2. AFLP case managers refer adolescent clients with suicide risk and other mental health problems to needed mental health services.		X		
3. AFLP case management strategies include both youth development and risk reduction activities and services.		X		
4. MCAH Division works with the Adolescent Health				

Collaborative and other key partners to promote best practices in mental health and suicide prevention. This includes particular attention to the foster youth population.				
5. Local MCAH Programs work with local collaboratives to address Adolescent Health issues including youth development, drug abuse prevention and intervention, and mental health issues including suicide prevention.				X
6. Local MCAH Programs screen clients for signs of depression.			X	
7. The Department of Education authorizes school districts to use a portion of their Professional Development Block Grant funding to pay for suicide prevention training for school teachers.				X
8. The Department of Mental Health administers grants to local programs under the MHSA. Local programs provide direct services	X	X	X	X
9.				
10.				

b. Current Activities

The DMH Office of Suicide Prevention provides suicide hotline referrals, a link to the California Strategic Plan on Suicide Prevention, and fact sheets on suicide. It implements the MHSA 3-Year Program and Expenditure Plan. LHJs continue to submit their 3-year plans for MHSA funds. DMH published, distributed, and educated stakeholders on the Statewide Stigma and Discrimination Reduction Plan which will be used by LHJs to develop local plans. CDE publishes an extensive list of youth suicide prevention resources on its website. CIPPP provides regional data (hospital discharges, fatalities) on youth self-harming behavior to LHJs, suicide and self-harm abstracts from select journals.

CIPPP continues to work with AAP-CA, the California Academy of Family Physicians, and members of the American Academy of Child and Adolescent Psychiatrists to provide summaries of recent research on the occurrence and prevention of child and adolescent self-harming behaviors.

Nine MCAH LHJs identified issues relating to adolescent mental health as one of their priorities, but none identified youth suicide. LHJs work with local collaboratives to address adolescent suicide prevention. Under a contract with MCAH, CAHC compiled several county-level adolescent health indicators, including suicide rates. CAHC developed a tool for LHJs to use in assessing local community support for positive youth outcomes as reflected by the health indicators.

c. Plan for the Coming Year

DMH will continue to assist counties in implementing their MHSA three year plans and plans to publish a summary of the counties' activities. LHJs will continue to implement their three year plans for MHSA PEI funding. MCAH will continue to work with CAHC and others to promote best practices in mental health and to investigate best practices in suicide prevention. MCAH will continue to work with programs in the LHJs, including the CPSP, AFLP, and BIH programs, to identify and refer adolescents at risk for suicide to appropriate assessment and treatment. MCAH will work to maintain and improve appropriate linkages between other State departments to address systemic barriers and create pathways to service delivery. MCAH will also continue to promote providers' screening, assessment, education, and referral to treatment and services for adolescent clients at risk of alcohol use, drug abuse, domestic violence, depression, and stress. MCAH will encourage LHJs to incorporate mental health and behavioral issues into LHJ activities as they work toward improving the health and well-being of the MCAH population within their boundaries. CIPPP will continue to provide regional summaries of data on the occurrence of self-

harming behavior among youth, and will continue to provide its SafetyLit Weekly Update and update its archives.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	68.5	68.2	67.2	67.5	67.8
Annual Indicator	67.1	66.9	67.3	73.8	73.8
Numerator	4546	4471	4577	4641	
Denominator	6770	6679	6800	6288	
Data Source				CA Birth Statistical Master File 2008; CCS, 2008	CA Birth Statistical Master File
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	68.1	68.4	68.4	68.7	68.7

Notes - 2009
A manual indicator is reported for 2009 based on 2008.

Notes - 2008
Source: State of California, Department of Public Health, Center for Health Statistics, 2008 California Birth Statistical Master File and California Children Services (CCS), Approved Hospitals for NICUs as of December 2008.

Tabulations by place of occurrence were done by the MCAH Program. For 2008 calculations, MCAH included births at three birthing hospitals that share a hospital campus or building with a CCS-approved Children's Hospital that has an appropriate level NICU (i.e., the birthing hospital and children's hospital are administratively different hospitals, but are co-located in the same building or campus).

Data from previous years should not be compared to 2008.

Notes - 2007
Source: State of California, Department of Public Health, Center for Health Statistics, 2007 California Birth Statistical Master File and California Children Services, Approved Hospitals for NICUs as of December 2008. Tabulations, by place of occurrence, were done by the MCAH Program.

a. Last Year's Accomplishments
NPM 17, the percent of Very Low Birth Weight < 1500 grams (VLBW) infants delivered at facilities for high-risk deliveries and neonates, has fluctuated around 67 percent since 2000. The lowest

point was in 2001. In 2008, 73.8 percent of VLBW infants were delivered at such facilities, which is far short of the Healthy People 2010 objective of 90 percent. There is some variation by race/ethnicity in the percent of VLBW infants delivered at facilities for high-risk deliveries and neonates. In 2008, Native American/ Alaska Native had the lowest percentages of these VLBW deliveries at NICU facilities at 56.7 percent. African Americans had the highest percent (78.1), followed by Whites (76.4), Asians (72.3) and Pacific Islanders (71.9).

The California figures are based on data from hospitals designated by the CCS program as Regional, Community or Intermediate NICUs. For 2008, there were 114 CCS-approved NICUs in California; however, not all facilities providing care for VLBW infants seek certification by CCS. Fourteen RPPC provide planning and coordination to ensure that all high-risk patients are matched with the appropriate level of care. The RPPC develops communication networks on many perinatal topics, disseminates education materials including toolkits, assists hospitals with data collection for quality improvement, and provides hospital linkages to CPeTS.

MCAH has two data projects which monitor perinatal outcomes: IPODR (http://www.cdph.ca.gov/data/indicators/Pages/InfantPerinatalOutcomesDataReport.aspx) and the California Perinatal Profiles (http://perinatalprofiles.berkeley.edu/). The IPODR website includes an annual county profile report based on California Birth/Death Vital Statistics and Hospital Discharge Data aggregated at the zip code level. The California Perinatal Profiles website provides both public (state and regional) and confidential (hospital specific) data to aid quality improvement in maternity hospitals in California.

Efforts continue to improve data collected from birth certificates. Since 2004, OVR has collaborated with MCAH working with RPPC leaders to plan and present a statewide series of birth data quality trainings. The interactive presentations included discussions of difficulties gathering data, and explanations of medical terminology including illnesses, complications and procedures of labor and delivery. Twelve newly developed fact sheets from the Birth Defects Monitoring Program were included in the training packets. Awards for excellence and improvement in data collection were presented to hospitals.

MOD collaborated with RPPC and LHJs to implement the Preterm Labor Assessment Toolkit in 30 California hospitals, triaging women with suspected preterm labor. The importance of perinatal emergency preparedness continues to be an active topic and RPPC Region 4 selected this as its annual quality improvement topic.

CMS began collaborating with CPQCC to develop a plan to monitor outcomes of infants/children, 0-3 years of age, in the newly restructured High Risk Infant Follow-up Program. This monitoring capability, coupled with perinatal/neonatal CPQCC data elements, will allow most of infant outcomes assessed in association with perinatal/neonatal care.

MCAH in collaboration with CPQCC and CPeTS had implemented an electronic data system, to allow tracking of neonatal transports, and monitoring of outcomes. This web-based perinatal transport data collection system helps to identify data elements to guide perinatal transport quality improvement. There are 150 participating hospitals.

In 2008, PQIP completed its first multi-hospital QI collaborative, to prevent healthcare-associated infections using the IHI Model. This successful collaborative was an extension of the 2007-08 Nosocomial Infection Demonstration Project, which included 20 of 21 CCS Regional NICUs. These combined projects resulted in one-third of all CPQCC member NICUs participating in efforts to decrease nosocomial infection.

RPPC leadership was instrumental in submitting a National Quality Forum (NQF) Perinatal Measure for Infants under 1500g Delivered at Appropriate Site, which was accepted in October 2008.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The fourteen RPPC provide regional planning and coordination and ensure that the needs of high-risk patients are matched with the appropriate level of care.				X
2. The CA Perinatal Transport Systems (CPeTS) assist in the referral of high-risk pregnant women and newborn infants by providing bed availability status for regional CCS approved NICUs, updated daily, on the CPeTS website.		X		
3. RPPC and CPeTS assist hospitals with data collection and quality improvement activities.				X
4. MCAH shares information with and the Emergency Preparedness Office (EPO) regarding Perinatal Disaster Preparedness.				X
5. The CPQCC reports on neonatal care for hospital/NICU members of CPQCC, provides to CCS a useful and uniform reporting scheme for comparative assessment of hospitals on Level of care for neonates.				X
6. The Improved Perinatal Outcome Data Reports (IPODR), which include county profiles and other reports, provide information on which to base health planning and allocation decisions, and evaluation of these decisions.				X
7. MCAH and OVR collaborate to improve birth data quality by developing and convening a series of trainings with the assistance of RPPC regional leaders to Improve Data Quality on the California Birth Certificate.				X
8. The California Perinatal Profiles website provides both public (state and regional) and confidential (hospital specific) data to aid continuous quality improvement to all maternity hospitals.				X
9. RPPC reviews regional cooperative transport agreements during annual hospital site visits. This activity is based on the toolkit developed by RPPC and CMS, which includes policy development, outreach education, and review of outcome data to assist h				X
10.				

b. Current Activities

RPPC and CPeTS continue matching high-risk patients with the appropriate level of care. The RPPC leaders review birth outcomes data, Perinatal Profiles, and transport agreements with hospitals during site visits.

All CCS approved NICUs are required to submit data annually, and CPQCC continues to retrieve and analyze NICU data. There were 128 CPQCC member hospitals in 2009. The 2008 CPQCC dataset included 11,994 "Big Babies" (>1500 grams), 6677 "Small Babies" (<1500 gram), and 7122 acute transports. The CPQCC databases have expanded and include: 1) Vermont Oxford Network Small Baby <1500 grams; 2) CPQCC High-Acuity, Big Baby 3) All-California Neonatal Transport Database; 4) All-California, Rapid-Cycle Maternal/Infant Database, including Census, Birth Certificate and OSHPD Hospital Discharge data linked to CPQCC outcomes, and 5) as of 2009, the CCS online High-Risk Infant Follow-up (HRIF) dataset which follows eligible infants 0-3 years of age.

RPPC, with OVR, is providing eight trainings beginning in March 2010 emphasizing the

importance of hospital administration, nursing and birth clerks working together to accurately report birth data.

c. Plan for the Coming Year
RPPC and CPeTS continue their work in regional planning and coordination, matching the transport of high-risk patients with the appropriate level of care and assisting hospitals with data collection and quality improvement surrounding patient transfer. CPeTS will present two regional trainings in 2010 and develop an on-line training system.

CMS and CPQCC will continue to respond to member questions, and analyze data reports for CCS-approved NICUs, addressing outliers and concerns about quality of care. RPPC, with OVR, will present Birth Data Trainings emphasizing administration, nursing and birth clerks collaborating to obtain and accurately report birth data. RPPC regional leaders will discuss opportunities for nursing staff to work with birth clerks for enhanced birth data reporting. Following this series staff will strategize the next steps to improve data quality.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	89.4	87.1	86.7	86.9	87.1
Annual Indicator	86.6	85.9	82.9	82.4	82.4
Numerator	470955	478973	459175	445108	
Denominator	544118	557642	554107	539978	
Data Source				CA Birth Statistical Master File, 2008	CA Birth Statistical Master File
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	87.3	87.5	87.5	87.5	87.5

Notes - 2009
A manual indicator is reported for 2009 based on 2008.

Notes - 2008
Source: State of California, Department of Public Health, Center for Health Statistics, 2008 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program. Cases in which the time of the first prenatal visit was unknown were excluded from the denominator.

Notes - 2007
Source: State of California, Department of Public Health, Center for Health Statistics, 2007 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program. Cases in which the time of the first prenatal visit was unknown were excluded from the denominator.

a. Last Year's Accomplishments
Since 2005, NPM 18 has steadily decreased from 86.6 percent to 82.4 percent. Only Whites met the statewide annual objective for 2008 at 86.9%. Whites were more likely to receive prenatal care in the first trimester than women who were Asians (86.6 percent) Hispanic (79.9 percent), African American (78.3 percent), Pacific Islander (67.4 percent) or American Indian (66.4 percent). In the 1980s, in order to improve prenatal care utilization, California expanded Medi-Cal eligibility criteria, improved access to Medi-Cal through presumptive and continuous eligibility, waived the assets test, and reduced application paperwork.

CPSP, AFLP, BIH, WIC, AIIHI and local MCAH continued to provide case management services and linkages to medical care for their target populations. CPSP provides perinatal support services to approximately 165,000 women a year, and the approximately 1500 providers receive a higher reimbursement rate for offering additional health education, nutrition and psychosocial support services. CPSP providers receive a bonus for providing prenatal care in the first trimester.

In May 2009, PHCC launched the EveryWomanCalifornia website which provides information to consumers about the importance of being healthy before pregnancy. It also focuses on the importance of planning for pregnancy and emphasizes early entry to prenatal care. A joint MOD/ACOG project coordinated by the PHCC convened a multidisciplinary work group to begin development of clinical guidelines to optimize the post partum visit as a first step in providing interconception care, especially for women who have had a poor pregnancy outcome.

MCAH provided ethnically diverse staff for recruiting clients into care, and LHJs employed a variety of methods to target diverse populations. MCAH provided a local toll free line for residents to obtain referrals to low cost health insurance and prenatal care. In addition, each jurisdiction delivered outreach in a way appropriate to their population's needs.

L.A. County developed, updated and expanded perinatal resources in its "211" phone number that provides access information at a single number that residents can call to obtain information. They are improving visibility of this resource for women, especially those with low incomes.

LHJs collaborated with schools to incorporate prenatal care essentials into curricula for local schools, nursing schools and medical residency programs.

About 40 percent of all births in California are unintended (38). California's Family PACT Program provided no-cost family planning services to all California residents with incomes at or below 200 percent of the federal poverty level, and, insofar as these services help to reduce the rate of unintended pregnancy, they also contribute indirectly to more timely prenatal care, since women with planned pregnancies seek care earlier.

AIM Program administered by MRMIB provided low-cost coverage for over 7000 pregnant women with incomes from 201-300% of the Federal Poverty Level.
In spite of efforts to increase the number of women who receive prenatal care in the first trimester, the following obstacles remain: delays due to lack of awareness of Medi-Cal Presumptive Eligibility Program, delays due to the Medi-Cal enrollment process, economic downturn leading to more uninsured and high rates of unintended pregnancy.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CPSP provides Medi-Cal eligible women with prenatal care, health education, and support services.	X	X		X
2. BIH identifies pregnant and parenting African American women who are at risk for poor birth outcomes and provides them assistance in accessing and maintaining health care and other support services		X	X	X
3. AFLP provides case management services to pregnant adolescents at risk of poor birth outcomes; services include nutritional and prenatal counseling and referrals for prenatal and other medical services.		X	X	
4. AIIHI serves prenatal and parenting American Indian women with direct health care services and case management services.	X	X		
5. MCAH work to provide ethnically diverse staff for recruiting clients into care, and LHJs employ a variety of methods to target diverse populations.		X	X	X
6. Family PACT Program provides no-cost family planning services to low-income residents; these services help to reduce the rate of unintended pregnancy, and contribute indirectly to increased utilization of prenatal care.	X			X
7. PHCC plays a pivotal role in relaying the message of the importance of intended pregnancy, pregnancy spacing and preconception care to local communities.			X	X
8. LHJs collaborate with schools to assure the incorporation of prenatal care essentials into curricula for local schools, nursing schools and medical residency programs.				X
9. AIM program provides low-cost health coverage to pregnant women. Their newborns may be covered by the Healthy Families Program. AIM is for middle-income families who don't have adequate health insurance and whose income is too high for no-cost Me		X		
10.				

b. Current Activities

CPSP continues to provide comprehensive perinatal services, including routine obstetric care, nutrition, health education, and psychosocial services, to its clients. Providers receive a bonus for each woman receiving an initial combined assessment and the initial pregnancy office visit within 4 weeks of entry into care. CPSP providers are eligible for payment of one additional obstetrical visit to ensure continuity of care for each CPSP patient.

Family PACT continues to provide no-cost family planning services to all California residents with incomes at or below 200 percent of the FPL. The AIM program continues to provide low-cost health coverage to pregnant women with inadequate coverage and whose incomes are too high for Medi-Cal.

LHJs will continue to collaborate with schools to incorporate prenatal care essentials into curricula for local schools, nursing schools and medical residency programs.

PHCC continues to coordinate the MOD/ACOG post-partum project which will help clinicians to provide information and counseling to clients about healthy behaviors between pregnancies, including optimal pregnancy spacing and the importance of early access to prenatal care, especially for women with chronic medical conditions.

MCAH LHJs will continue outreach to pregnant women and assist with referrals and enrollment in Medi-Cal and other health plans.

c. Plan for the Coming Year
MCAH will continue to work with LHJs to improve outreach to women of childbearing age and pregnant women and provide linkages to early prenatal care.

CPSP, AFLP, WIC, BIH, and AIIHI will continue to provide case management services and linkages to medical care for their target populations.

CPSP plans include expanding provider trainings to include a web-based provider overview training; and providing local data on CPSP billing patterns to evaluate local CPSP programs. Local CPSP coordinators will also continue provider recruitment, and will monitor and strengthen the utilization of CPSPs scope of benefits by training providers and practitioners in documentation, program services, and developing materials and evaluative reports on the efficacy of services. MCAH and its LHJs undertake these activities to ensure the availability and effectiveness of CPSP services, even in this era of budget constraints, and to achieve improvements in first trimester entry into prenatal care. MCAH is working to consolidate data on beneficiaries, paid claims, birth outcomes, and hospital discharge to develop baseline data on the efficacy of CPSP services.
AIM will continue to provide low-cost health insurance to pregnant women with incomes between 210 and 300% of FPL.

D. State Performance Measures

State Performance Measure 1: *The percent of children birth to 21 years enrolled in the CCS program who have a designated medical home.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		50	70	84.2	89.5
Annual Indicator	57.9	76.4	84.2	89.0	83.6
Numerator	92903	123748	146423	152893	145461
Denominator	160499	162023	173850	171885	174008
Data Source				CMS Net and LA County	CMS Net and LA
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	89.5	89.5	89.5	89.5	

Notes - 2009
This measure is the percent of children birth to 21 years enrolled in the CCS program who have a designated medical home.

The data are from CMS Net data for all counties for FY 2009-10.

The percentage is lower for this annual indicator for 2009-10 due to a data adjustment so that the medical home field will only accept a provider who is on the provider master file. In prior years,

any text could be entered in the medical home field, including a comment, and would be counted as a medical home.

This is the final year for reporting on this measure.

Notes - 2008
This measure is the percent of children birth to 21 years enrolled in the CCS program who have a designated medical home.

The data are from CMS Net data for 57 counties and data from Los Angeles County CCS program for FY 2008-09.

Notes - 2007
This measure is the percent of children birth to 21 years enrolled in the CCS program who have a designated medical home.

The data are from CMS Net data for 56 counties and data from local county CCS programs for the remaining 2 counties for FY 2007-08.

a. Last Year's Accomplishments
State Performance Measure (SPM) 01, the percent of children birth to 21 years enrolled in the CCS program who have a designated medical home for 2009 is 83.5 percent compared to 88.9 percent in 2009. The percentage is lower for this annual indicator because the medical home field has been adjusted so that it will only accept a provider who is on the provider master file. In prior years, anything could be entered, including a comment, and would be counted as a medical home. The definition of medical home continues to be used interchangeably with primary care physician (PCP).

SPM 01 was a new California SPM in 2006. There is a medical home NPM, NPM 03: The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. NPM 03 is from the CSHCN Survey for California and is a different population than the CCS program.

County CCS programs assessed whether CCS eligible children had a documented primary care physician/medical home and worked at improving this documentation, however, they have no way to distinguish a PCP from a true medical home.

The Healthy People 2010 Objective is that every child with special health care needs will receive comprehensive care in a medical home, and though this is probably not attainable in this timeframe, the CCS program does have a goal to eventually reach this objective. The CMS stakeholder group involved in developing the strategic plan for the Title V 2005 Needs Assessment has identified having a medical home for children enrolled in the CCS program as one of the top three state priorities. The work to increase the number of FCC medical homes for CSHCN as well as policy development on medical home and the medical home initiative for CSHCN are on hold due to staffing cuts and budget issues.

The goal is to complete the data definition for the "medical home" field to reflect where the child receives comprehensive and coordinated, ongoing medical care requires work, including having physicians identify whether they are a true medical home and having the local programs assist with identifying true medical homes.

CCS collaborated with CHLA and the CA Epilepsy Foundation on a grant from HRSA for Improving Access to Care for Children and Youth with Epilepsy in CA; also known as "Project Access". One of the goals of the project was to improve access to health and other services and support related to epilepsy by facilitating development of medical homes for medical care for children and youth (0-18) with epilepsy in California especially those residing in medically

underserved areas. Although Project Access ended in May, 2009, Sonoma county CCS continued to collaborate with the FQHC to support the medical home development for children with epilepsy in Sonoma County.

FVCA provided trainings for families and professionals on the Medical Home and distributed binders to help families organize healthcare information and medical records. FVCA developed a "resource referral pads" to physicians that list local resources for families. Through the PHL network, developed a Hospital Discharge Questionnaire to ensure families have the information needed to care for their child at home upon discharge.

CRISS has applied to CMS for funding to conduct another statewide survey on the four federal MCHB core performance measures concerning family-centered care, including presence of medical homes. The survey results will be used for comparison with the statewide survey on those measures conducted by CRISS in 2005.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to collaborate with CHLA on the grant from HRSA for Improving Access to Care for Children and Youth with Epilepsy in California		X		
2. Evaluation by county CCS programs to determine if children have a medical home and explore improvement strategies.				X
3. FVCA provides trainings for families and professionals on the Medical Home Initiative and distributes binders to help families organize healthcare information and medical records.				X
4. FVCA Agencies provide “resource referral pads” to physicians that list local resources for families.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Although Project Access has ended, Sonoma county CCS continues to collaborate with the FQHC to support the medical home development for children with epilepsy in Sonoma County.

Due to budget cuts, work is on hold for utilizing the Federal MCHB grant awarded to the USC's UCEDD at CHLA for collaboration with CRISS, CMS, and FVCA to implement the strategies around increasing the number of FCC medical homes for CSHCN and the number/percent of CCS children who have a designated medical home. Work is also on hold for developing a policy letter for CCS regarding the medical home for CCS clients, particularly authorization of the medical home and ramifications of this authorization due to cuts.

Local CCS programs will continue an evaluation to determine if children have a medical home and explore improvement strategies.

FVCA continues to provide trainings for families and professionals on the Medical Home Initiative and distributes binders to help families organize healthcare information and medical records.

The "Resource Referral Pads" (and quick reference guides for pediatric office staff) for the 14

CRISS counties continue to be available on the CRISS website. The pads list local resources for families and are distributed to physicians in the local areas. CRISS is awaiting the results of the application to CMS for funding to conduct another statewide survey on the four federal MCHB core performance measures concerning family-centered care, including presence of medical homes.

c. Plan for the Coming Year

Sonoma county CCS will continue to collaborate with the FQHC and support the medical home development for children with epilepsy in Sonoma County. Local CCS programs will determine if children in the CCS program have a medical home and how to improve performance regarding effective case management.

FVCA will provide trainings for families and professionals on the Medical Home and distribute binders to help families organize healthcare information and medical records. 4. Referral pads to families and the quick reference guides for pediatric office staff will be available on the CRISS website. CRISS will conduct a statewide survey if awarded the funding through the State CMS on the four federal MCHB core performance measures concerning family-centered care, including presence of medical homes. The survey results would be used for comparison with the statewide survey conducted in 2005.

State Performance Measure 2: *The ratio of pediatric cardiologists authorized by the CCS program to children birth through 14 years of age receiving cardiology services from these pediatric cardiologists.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		0	0	0	0
Annual Indicator	0.0	0.0	0.0	0.0	0.0
Numerator	137	130	137	151	162
Denominator	67267	57865	56034	55198	52625
Data Source				CCS Program	CCS Program
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	0	0	0	0	

Notes - 2009

This measure is the ratio of pediatric cardiologists authorized by the CCS program to children birth through 14 years of age receiving cardiology services from these pediatric cardiologists.

The data is from CCS program listing of approved providers at Cardiac Special Care Centers and CCS ICD 9 codes for cardiac and cardiac related diagnoses for FY 2009-10.

For 2009-10, the ratio is 1:325 due to an increase in the number of cardiologists and a decrease in the number of CCS clients due in part to closure of some inactive cases with cardiac diagnoses and due to LA County being included in CMS Net so no extrapolation was needed. The increase in cardiologists is primarily in one area of Northern CA due to very aggressive recruiting, and there continues to be significant deficits of pediatric cardiologists in all other areas.

This is the last year for this measure.

Notes - 2008
This measure is the ratio of pediatric cardiologists authorized by the CCS program to children birth through 14 years of age receiving cardiology services from these pediatric cardiologists.

The data is from CCS program listing of approved providers at Cardiac Special Care Centers and CCS ICD 9 codes for cardiac and cardiac related diagnoses for FY 2008-09.

There was an error in the number of children birth through 14 years for 2006-07 and the corrected number is 57865, with the resultant ratio of 1:445.

For 2008-09, the ratio is 1:366 due to an increase in the number of cardiologists and a decrease in the number of CCS clients due to closure of some inactive cases with cardiac diagnoses. The increase in cardiologists is primarily in one area of Northern CA due to very aggressive recruiting, and there continues to be significant deficits of pediatric cardiologists in all other areas.

The indicator is 1:350 for 2009-2012.

Notes - 2007
This measure is the ratio of pediatric cardiologists authorized by the CCS program to children birth through 14 years of age receiving cardiology services from these pediatric cardiologists.

The data is from CCS program listing of approved providers at Cardiac Special Care Centers and CCS ICD 9 codes for cardiac and cardiac related diagnoses for FY 2007-08.

There was an error in the number of children birth through 14 years for 2006-07 and the corrected number is 57865, with the resultant ratio of 1:445.

For 2007-08, the ratio is 1:409 due to a small increase in the number of cardiologists and a decrease in the number of CCS clients due to closure of some inactive cases with cardiac diagnoses.

The indicator is 1:400 for 2008-2012.

a. Last Year's Accomplishments
SPM 02, the ratio of pediatric cardiologists authorized by the CCS program to children birth through 14 years of age receiving cardiology services from these pediatric cardiologists is 1: 325 for FY 2009-10. This is the fifth and final year for this measure and there is a 7% increase in the number of cardiologists and a 5% decrease in the number of children seen by these cardiologists from FY 2008-09; the resultant ratio is improved from FY 2008-09 and improved from all other years, but there are still significant deficits of pediatric cardiologists. SPM 02 addresses provider capacity for the subspecialty of pediatric cardiologists. There are concerns over the shortage of pediatric subspecialty providers throughout the state, particularly for CSHCN with complex medical conditions. This measure was selected because children with diagnoses related to congenital heart disease make up the largest group of children enrolled in CCS, and because of the shortage of pediatric cardiologists throughout the state. This may be a result of an insufficient pool of pediatric cardiologists in the country, and difficulty recruiting this subspecialty to California due to the high cost of living, lower salaries, and lower reimbursement. The continued increase in pediatric cardiologists for 2009-10 was primarily localized again to Northern California and particularly to continued aggressive recruitment at Stanford. All other areas of the state and especially Southern California have a continued insufficient pool of pediatric cardiologists. One fall out from not having sufficient numbers of pediatric cardiologists is that with the increase in obesity, pediatric cardiologists are not able to evaluate all the children who may be having cardiovascular disease due to their obesity.

For the past few years, CCS has been intentionally closing cases where the children/youth no

longer need follow-up by specialists. This case closure may have resulted in a lower number of active cases in CMS Net with the ICD-9 cardiac related diagnoses.

The ratio for this measure was obtained by determining the number of active cases in CMS Net with a select number of cardiac ICD-9 codes (390.0 through 429.9, 440.0 through 448.9, 745.0 through 747.9, 780.2, 785.0 through 785.3, and 786.50 through 786.51). The assumption is that CCS cases represent approximately 40 percent of pediatric cardiologists' caseloads. Pediatric cardiologists care for 52,625 children birth through 14 years of age in California. As the number of pediatric cardiologists at all the CCS Hospitals is 162, the ratio is one pediatric cardiologist per 325 children birth through 14 years of age. This is a low estimate because some pediatric cardiologists continue to see their youth past 14 years of age.

Work has been ongoing to improve the SCC directories so that there is a better assessment of the number of pediatric cardiologists at the SCCs. Due to staffing shortages, CMS has not been able to devote time to working with pediatric cardiologists in the state on ways to increase their numbers.

CMS maintained the CMS Cardiac Technical Advisory Committee (TAC) to consult by telephone on cardiac issues as needed. Staffing did not allow for face to face committee meetings.

There have been an increasing number of cardiac internists added to SCCs to Improve CCS program capacity to serve older teens and Youth with Special Health Care Needs (YSHCN) who are transitioning to adult services.

The directory of core team members at the Pediatric Cardiac SCCs has had some updates this past year.

The Transition Workgroup has helped to develop transition guidelines which were disseminated to the local programs, regional offices and MTU programs in April 2009 and are available on the CMS website http://www.dhcs.ca.gov/services/ccs/Documents/ccsin0901.pdf . The Workgroup continued to work on the Transition Toolkit and has aimed for completion fall 2010. CCS no longer had staff to attend the Transition Workgroup meetings.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Maintain and strengthen the provider network for CSHCN through the CMS Cardiac Technical Advisory Committee.				X
2. Improve CCS program capacity to serve older teens and YSHCN who are transitioning to adult services.				X
3. Annually update the directory of core team members at the Pediatric Cardiac SCCs to evaluate the availability of pediatric subs				X
4. CCS Transition Workgroup and other partners evaluate and implement strategies to address provider capacity and provide a guide for the transition process.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
CMS maintains the CMS Cardiac TAC to consult by telephone on cardiac issues as needed. Staffing does not allow for face to face committee meetings.

CCS continues to improve program capacity to serve older teens and YSHCN who are transitioning to adult services. CCS also continues to evaluate the CCS provider network for Cardiologists to care for teens in transition to adult care.

CCS continues to update the directory of core team members at the Pediatric Cardiac SCCs to evaluate the availability of pediatric subspecialty physicians in the state available to CSHCN as staffing allows.

The Transition Workgroup is continuing to work on the Transition Toolkit and is aiming for completion Fall 2010.

c. Plan for the Coming Year
CMS will continue to maintain the CMS Cardiac TAC to consult by telephone on cardiac issues as needed.

CCS will improve its program capacity to serve older teens and YSHCN who are transitioning to adult services and plans to evaluate the CCS provider network for Cardiologists to care for teens in transition to adult care.

CMS will continue update the directory of core team members at the Pediatric Cardiac SCCs to evaluate the availability of pediatric subspecialty physicians in the state available to CSHCN as staffing allows.

The Transition Workgroup will continue to work on the Transition Toolkit and is aiming for completion in fall 2010.

State Performance Measure 3: *The percent of women, aged 18-44 years, who reported 14 or more "not good" mental health days in the past 30 days ("frequent mental distress").*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		13.6	12.8	12.7	12.6
Annual Indicator	12.9	13.4	13.4	14.7	14.7
Numerator	877547	918931	918149	1006273	
Denominator	6822505	6870676	6865507	6839199	
Data Source				CA Women's Health Survey, 2008	CA Women's Health Survey
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	12.5	12.4	12.4	12.4	

Notes - 2009

A manual indicator is reported for 2009 based on 2008.

Notes - 2008
Source: California Department of Public Health, California Women's Health Survey (CWHS), 2008.

Numerator: Number of women, 18-44 years of age, who reported 14 or more not good mental health days in the past 30 days.

Denominator: Number of women, 18-44 years of age, reporting the number of not good mental health days. Numerator and denominator were weighted using the California Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050, July 2007.

Notes - 2007
Source: California Department of Public Health, California Women's Health Survey (CWHS), 2007. Numerator: Number of women, 18-44 years of age, who reported 14 or more not good mental health days in the past 30 days. Denominator: Number of women, 18-44 years of age, reporting the number of not good mental health days. Numerator and denominator were weighted using the California Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050, May 2004.

a. Last Year's Accomplishments
SPM 03, the percent of women aged 18-44 years who reported 14 or more "not good" mental health days in the past 30 days, became a new California SPM in 2006. SPM 03 was 14.7 percent in 2008, an increase from the most recent previous years. Since 2000, this measure has fluctuated between 12.9 and 15.7 percent.

There is increasing recognition of the importance of mental health promotion and early detection and treatment of mental health problems. MCAH plays an important role in identifying mental health needs, intervening before mental health problems become debilitating, and facilitating access to integrated, comprehensive treatment.

MCAH staff continues to actively participate in the PHCC which developed a website with an emotional wellness component to help women of childbearing age achieve optimal mental health, improve their well-being and help ensure good outcomes for their babies.

MCAH is a key collaborator in the University of California, Berkeley's (UCB) Bright Beginnings grant, funded by HRSA. The project aims to improve the California MCAH workforce's capacity to address maternal mental health issues in a timely and effective manner through continuing education courses. The Bright Beginnings project convened a conference on maternal mental health for primary care providers in Berkeley (Northern California) in November, 2008. The conference examined women's experiences dealing with mental health issues in pregnancy and postpartum, explored what is being done in California to integrate mental health and primary care services, and identified successful ways to address barriers and select among promising practices.

CDAPP provides various types of psychosocial information for providers on the MCAH website. Topics include depression and diabetes; domestic violence; screening for perinatal depression; and stress checks. The Sweet Success provider trainings include instruction on how to use the Edinburgh Postpartum Depression Scale.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. CPSP, BIH, AFLP, DV, CDAPP, and local MCAH programs--include mental health assessment and/or referral, as well as treatment in some cases		X		
2. Local MCAH staff improved the ability to match client needs to resources with increased resource availability and program capacity enhanced by MHSA)funding		X		
3. MCAH report results from the California Women's Health Survey and California's Maternal and Infant Health Assessment survey at meetings and on CDPH websites, covering postpartum depression and mental health issues				X
4. MCAH informs the research and program communities by analyzing and presenting data on mental health from the California Women's Health Survey and from the Maternal and Infant Health Assessment survey				X
5. MCAH staff participate in the Preconception Health Council of California				X
6. MCAH monitors the preconception health website which has an emotional wellness component to help women of childbearing age		X		
7. UCB Bright Beginnings project held it second conference, "Maternal Mental Health over the Life Course", at Los Angeles on March 15, 2010				X
8.				
9.				
10.				

b. Current Activities

CPSP, BIH, AFLP, CDAPP, PHHI and local MCAH programs include screening, assessment and/or referral, and some include treatment in their program. Programs address general depression, as well as postpartum depression in the populations they serve. CDAPP continues to encourage its providers to do mental health screening at the postpartum period and is revising the Sweet Success guidelines with the most current information on use of the Edinburgh Postpartum Depression Scale. Results of the CWHS and MIHA survey related to postpartum depression and other mental health topics are presented by MCAH at conferences, meetings and on the CDPH website.

The UCB Bright Beginnings project held it second conference, "Maternal Mental Health over the Life Course", at L.A. on March 15, 2010. The conference discussed the knowledge and implications of the life course model with respect to maternal mental health and its application in the delivery of services; explored the best practices for screening and treatment of mental health problems for vulnerable populations; and examined alternative therapeutic models of care for maternal depression and co-morbidities including diabetes, chronic pain and hypertension.

MCAH staff continues to actively participate in PHCC, focusing on the importance of achieving optimal health, including mental health, before pregnancy. MCAH monitors the preconception health website which has an emotional wellness component to help women of childbearing age.

c. Plan for the Coming Year

In the coming year, MCAH plans to: Maintain appropriate linkages with ADP, DMH, the Department of Rehabilitation, DSS, Medi-Cal, Office of Emergency Services; domestic violence), CDPH and DHCS to address systemic barriers and create pathways to service delivery

MCAH will continue to work on building the capacity of the provider network that delivers comprehensive perinatal services, addressing psychosocial assessment and reassessment during each trimester and postpartum, development of a care plan, appropriate referrals, and client follow-up MCAH will also continue to support and promote the incorporation of mental health and behavioral issues into local MCAH program activities. MHSA funding will be used by some LHJs to expand access and services for clients with mental/behavioral health issues, including women at risk for postpartum depression. Behavioral health services for adolescents continue to be increasingly addressed.

MCAH will continue to monitor the preconception health website which features links to information, tools and resources related to mental health and wellbeing for women of childbearing age. MCAH will also continue to work on improving CDAPP's capacity to address maternal mental health issues.

State Performance Measure 4: *The percent of women who reported drinking any alcohol in the first or last trimester of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		16.4	17.1	16.9	16.7
Annual Indicator	17.3	15.8	15.0	12.9	12.9
Numerator	92534	87117	82872	69329	
Denominator	534314	552433	552073	538959	
Data Source				MIHA, 2008	MIHA
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	16.5	16.3	16	15.7	

Notes - 2009
A manual indicator is reported for 2009 based on 2008.

Notes - 2008
Source: 2008 Maternal and Infant Health Assessment Survey, MCAH Program, California Department of Public Health.

Numerator: The number of women who delivered a live birth and who reported drinking any alcohol in the first or third trimester of pregnancy.

Denominator: The number of women who delivered a live birth that reported whether or not they consumed alcohol during pregnancy. Numerator and denominator are weighted to the representative number of resident women in the state who delivered a live birth that year.

Notes - 2007
Source: 2007 Maternal and Infant Health Assessment Survey, MCAH Program, California Department of Public Health. Numerator: The number of women who delivered a live birth and who reported drinking any alcohol in the first or third trimester of pregnancy. Denominator: The number of women who delivered a live birth that reported whether or not they consumed alcohol during pregnancy. Numerator and denominator are weighted to the representative number of resident women in the state who delivered a live birth that year.

a. Last Year's Accomplishments

SPM 04 is the percent of women who gave birth that reported drinking any alcohol in the first or last trimester of pregnancy. From 17.3% in 2005, it has declined to 12.9% in 2008. The related Healthy People 2010 target is that 94 percent of pregnant women report no drinking in the 30 days prior to the time the question is asked. [Data for SPM 04 are from the California MIHA and include women aged 15 years and older]

Mothers who reported drinking during the first or last trimester of pregnancy differed by racial and ethnic group. White women (24.7%) were most likely to drink any alcohol in the first or last trimester of pregnancy, followed by African American (16.8%) and Latina women (7.3 %).

An estimated 4,460 to 6,050 babies with FASD are born each year in California. [65, 66] FASD describes the range of effects that can occur in an individual whose mother used alcohol during pregnancy. These effects may include physical, cognitive, behavioral and/or learning difficulties with lifelong implications. FASD is the most common form of preventable brain injury in infants. MCAH seeks to improve birth outcomes for women at risk of alcohol abuse, including screening and referral for treatment services. Community-based prevention programs, including AFLP, BIH, CPSP, and CDAPP educate clients about FASD, identify mothers at high risk, and refer them for alcohol treatment services.

Over the past several years, MCAH has taken a leading role in promoting preconception health and health care, of which reduction of alcohol use by women of reproductive age is a key feature. MCAH's PHHI and representatives from MCAH actively participate in the PHCC. PHCC provides information, tools and resources to local communities pertaining to the importance of achieving optimal health for women before pregnancy, including the reduction of alcohol use, as a means to improving poor birth outcomes. PHCC has developed educational materials with a module that alerts women to the risks of having an unintended pregnancy while engaging in alcohol use. A preconception health website containing valuable information on topics that include perinatal substance use prevention was launched in May 2009.

Developed by Dr. Ira Chasnoff, the 4 P's Plus is a nationally-recognized screening tool that helps healthcare providers identify at-risk women who need additional evaluations by certified alcohol and drug counselors. Many LHJs are active in FASD prevention, and over 20 use Dr. Chasnoff's 4 P's Plus screening tools. Several also use county-specific strategies, coalitions and programs designed to address the issue of perinatal substance use and FASD. Strategies include incorporating substance use avoidance education into preconception care, school-based clinics, school curricula and community education opportunities. With a contract from MCAH, Dr. Ira Chasnoff's comprehensive report on perinatal substance use screening data, with specific findings on the use of the 4 P's Plus, was completed and released in October 2008.

Alameda County continues to implement their Pediatric System of Care Strategic Plan to improve care of substance-exposed children at risk for social/emotional, developmental, behavioral, psychological, and physical problems.

MCAH participates in the FASD Task Force, which consists of representatives from state and local agencies. In March 2009, the Task Force held a Strategic Planning Meeting to review its 2005-2010 Strategic Plan, re-examine its focus, and identify action steps for completing specified objectives.

In April 2009, ADP reconvened the Alcohol and Other Drug (AOD) Workgroup of the State Interagency Team (SIT) to address FASD prevention. This workgroup includes representatives from DMH, DSS, DDS, CDCR, Administrative Office of the Courts, ADP and MCAH.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 1. Community-based prevention and support programs, including AFLP, BIH, CPSP, DV, and CDAPP, educate clients about the dangers of alcohol use during pregnancy and refer high-risk women for alcohol treatment services.		X		
2. MCAH participates in the statewide FASD Task Force and the SIT AOD Workgroup.				X
3. LHJs conduct prenatal substance use screening programs, with several using the 4-Ps Plus mode.				X
4. Santa Cruz County Public Health nurses provide home-based support, education, and professional assistance for families with premature and/or substance exposed babies, or mothers with mental health issues.		X		
5. PHHI continues to augment and monitor its website which connects people working in preconception health and features links to tools and resources related to alcohol use prevention among women of reproductive age.				X
6. Alameda County continues to implement their Pediatric System of Care Strategic Plan to improve care of substance-exposed children at risk for social/emotional, developmental, behavioral, psychological, and physical problems.				X
7.				
8.				
9.				
10.				

b. Current Activities

LHJs continue to develop and strengthen coalitions with public/private agencies and providers to assess women at risk and develop appropriate referrals to resources. Many are working to develop coordinated and integrated systems of care to address issues of perinatal substance use based on evidence-based models and focusing on alcohol use during pregnancy in their presentations to providers and other interest groups.

Alameda County continues to implement their Pediatric System of Care Strategic Plan to improve care of substance-exposed children at risk for social/emotional, developmental, behavioral, psychological, and physical problems.

MCAH participates in the FASD Task Force. It plans to create a brochure that describes the purpose of the task force and an FASD fact sheet, both of which have been completed. An FASD task force website has been developed to complement its work on increasing legislators' awareness of FASD. The FASD Task Force is currently working on the formation of a legislative committee that specifically addresses FASD prevention and on bringing more prominence to the annual celebration of FASD Awareness Day on Sept. 9.

MCAH participates in the SIT AOD Workgroup which is working on a matrix of programs of its partner agencies that impact FASD and on consistent FASD messaging.

PHHI continues to monitor its website which connects people working in preconception health and features links to tools and resources related to alcohol use prevention among women.

c. Plan for the Coming Year

LHJs will continue to work on developing and strengthening coalitions with public/private agencies and healthcare providers to determine how best to identify women at risk and how to develop appropriate referral sources. LHJs will continue to develop and implement coordinated and integrated systems of care to address perinatal substance use prevention. MCAH will continue to participate in the FASD Task Force and the SIT AOD FASD Prevention Workgroup and will continue its efforts on preconception health education and promotion, including augmenting and monitoring its preconception health website.

State Performance Measure 5: *The rate of deaths per 100,000 adolescents aged 15 through 19 years caused by motor vehicle injuries.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	19.5	18.2	16.6	16.4	16.2
Annual Indicator	17.1	16.9	13.5	10.1	10.1
Numerator	474	485	399	304	
Denominator	2778214	2865987	2955147	3019105	
Data Source				CA Death Statistical Master File 2008	CA Death Statistical Master File
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	16	15.8	15.8	15.6	

Notes - 2009
A manual indicator is reported for 2009 based on 2008.

Notes - 2008
Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2008 California Death Statistical Master File [The ICD-10 codes for fatal MV traffic injuries are: V30-V79(.4-.9), V81.1, V82.1, V83-V86(.0-.3), V20-V28(.3-.9), V29(.4-.9), V12-V14 (.3-.9), V19(.4-.6), V02-V04 (.1,.9), V09.2, V80(.3-.5), V87(.0-.8), V89.2].

Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California. July 2007. Tabulations (by place of residence) were done by the MCAH Program.

Data for 2007 and 2008 should be not compared to data reported in previous years due to changes in methodology used for calculating this indicator. The methodology was updated for consistency between fatal and nonfatal injury reporting. The rate now includes only motor vehicle traffic incidents, and exludes motor vehicle non-traffic indicents. Rates for prior years using these updated inclusion criteria: 2000 = 12.6; 2001 = 17.0; 2002 = 20.0; 2003 = 19.4; 2004 = 18.1; 2005 = 16.6; 2006 =16.5.

Notes - 2007
Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2008 California Death Statistical Master File [The ICD-10 codes for fatal MV traffic injuries are: V30-V79(.4-.9), V81.1, V82.1, V83-V86(.0-.3), V20-V28(.3-.9), V29(.4-.9), V12-V14 (.3-.9), V19(.4-.6), V02-V04 (.1,.9), V09.2, V80(.3-.5), V87(.0-.8), V89.2]. Denominator: State of

California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California. July 2007. Tabulations (by place of residence) were done by the MCAH Program.

Data for 2007 should be not compared to data reported in previous years due to changes in methodology used for calculating this indicator. The methodology was updated for consistency between fatal and nonfatal injury reporting. The rate now includes only motor vehicle traffic incidents, and exludes motor vehicle non-traffic indicents. Rates for prior years using these updated inclusion criteria: 2000 = 12.6; 2001 = 17.0; 2002 = 20.0; 2003 = 19.4; 2004 = 18.1; 2005 = 16.6; 2006 =16.5.

a. Last Year's Accomplishments

The rate of motor vehicle deaths among 15-19 year olds declined significantly between 1990 and 2000, falling from 27.3 to 12.9 per 100,000. After large increases in 2001 and 2002, the rate has declined in each subsequent year. 2008 marked the steepest of these decreases, with the rate dropping to 10.1 per 100,000 in 2008. (Denominators are based on the number of adolescents, not the number of miles driven. See 2007 notes for clarification of changes in methodology used to calculate rates.) While there has been much improvement in this indicator, the rate is close to achieving the HP 2010 target of 9.2 per 100,000 in the overall population.

The highest rates of adolescent motor vehicle deaths were to Hispanics (10.5 per 100,000), and Whites (10.1 per 100,000). Asian and African American adolescents experienced death rates from motor vehicle injuries at a rate lower than the state average and the Healthy People 2010 objective. Other race/ethnic groups had too few motor vehicle deaths to be included in the comparison.

Motor vehicle injuries are the leading cause of death in California's teen population. Alcohol use by young drivers is especially dangerous. In 2002, 24 percent of drivers ages 15 to 20 who were killed in motor vehicle crashes were intoxicated.39 During the last decade, CHP has increased enforcement of driving under the influence/drunk driving (DUI) laws and has undertaken extensive education and public awareness programs. These include: "Sober Graduation," a program targeting high school seniors; the "Designated Driver Program;" and the "El Protector" program established in response to the high number of fatal accidents and DUI arrests involving Hispanic youth. SAC Branch heads the State Epidemiologic Work Group, which gathered and published data on alcohol and other drug consumption and consequences, i.e., risk factors for injuries to youth, and was completing the first phase of the Strategic Statewide Highway Safety Plan.

CIPPP and SAC coordinated with the California Coalition for Children's Safety & Health (CCCSH) -- volunteer representatives of California's life and health insurance companies, health and education professionals, consumer organizations and children's advocacy groups. State Assembly and Senate members seek out input from the CCCSH when child safety related bills are presented. CIPPP assisted 4 LHJs with tracking crashes, injuries, and deaths among teens to assess the California Graduated Licensing law's effect on injuries.

MCAH LHJs promote local maternal, child and adolescent health improvement programs. Injury prevention is an important component of local programs. The primary injury reduction focus for each jurisdiction varies depending upon the hazards identified for that community. Counties are expected to address injury prevention issues with their general funding allotment.

To raise funds in support of child injury and abuse prevention programs, the State sells personalized auto license plates, called "Kid's Plates," which features a heart, hand, star, or plus sign. The Kid's Plates Program provides a wide range of technical assistance to help foster effective regional and local injury prevention efforts and fund grants for training and equipment. CIPPP is the Kid's Plate Program administrator for SAC.

SAC coordinates activities including the Statewide Coalition on Traffic Safety, the Statewide Strategic Highway Safety Plan, and various child passenger safety programs. Other activities California has undertaken to reduce motor vehicle deaths among children include: passenger restraint laws; Graduated Driver Licensing (GDL); and vehicle safety improvements. Please see NPM 10 for additional activities.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Funds raised by sales of special car license plates, called Kid's Plates, support child injury and abuse prevention programs, including motor vehicle and pedestrian safety.		X		
2. The CIPPP provides technical assistance to LHJs.				X
3. LHJs participate with key agencies to promote and implement traffic safety training, use of bicycle helmets, swimming pool and playground equipment safety, and use of seat belts and child restraints.		X		
4. SAC Branch participates in the Statewide Coalition on Traffic Safety, which focuses on seat belt use and prevention of speeding and DUI.				X
5. LHJs are using the Child Death Review data to identify trends and raise awareness about deaths due to motor vehicle injuries.				X
6. LHJs conduct home safety evaluations when performing client home visits, and provide guidance on corrective actions when perilous situations are identified.		X		
7. SAC Branch leads the Statewide Strategic Highway Safety Plan to identify key safety needs and to provide a structure for data-driven decision-making.				X
8.				
9.				
10.				

b. Current Activities

Research articles on traffic safety among adolescents continue to be added to SafetyLit, an online source for current and past scholarly research about all aspects of injury prevention.. The State Epidemiological Work Group produced State and local Epidemiological Profiles on AOD consumption and consequences and provided a web based query system. SAC maintains Medical Crash Outcomes Data.

LHJs participate in Safe Kids Coalitions, traffic safety education, bicycle helmet distribution and education, and education on appropriate seat belt use. Humboldt County, for example, implemented a Youth Safe Driving Program, conducted focus groups on driving attitudes and behavior, launched DUI prevention and seat belt campaigns, and convened a Youth Safe Driving Subcommittee. This subcommittee conducted media outreach, seat belt observations at local high schools, a safe driving poster contest and safe driving classes.

Sutter County educated a high school community about teen drinking and driving using the program "Every 15 Minutes." Counties also use Child Death Review data to identify trends and raise awareness.

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California continues its GDL program. LHJs are working with local law enforcement agencies on the "Next Generation" Click it or Ticket program. Consistent public health messages will strengthen the impact of this campaign for the MCAH population.

MCAH continues to collaborate with SAC and other agencies.

c. Plan for the Coming Year
MCAH, SAC, CIPPP and LHJs will continue current activities as resources permit. The SAC Medical Crash Outcomes Data project will end unless it receives additional resources. Motor vehicle related injury control efforts include common statewide goals and priorities; strengthening injury prevention and control partnerships; sharing data, knowledge and resources; avoiding redundant activities; and leveraging existing resources, including funds, people and leadership attention, toward common objectives.

State Performance Measure 6: *The incidence of neural tube defects (NTDs) per 10,000 live births plus fetal deaths among counties participating in the California Birth Defects Monitoring System.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	7	5.2	6.4	6.2	6
Annual Indicator	6.7	7.0	6.0	5.7	5.7
Numerator	45	49	43	40	
Denominator	67365	70382	71609	70330	
Data Source				CBDMP, 2008	CBDMP
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	5.8	5.6	5.6	5.4	

Notes - 2009
A manual indicator is reported for 2009 based on 2008.

Notes - 2008
Source: State of California, Department of Public Health, 2008 California Birth Defects Monitoring Program (CBDMP) Registry.

Numerator: Confirmed cases of NTDs among live births and fetal deaths in monitored counties in 2008.

The provisional data for 2008 as well as all data reported in prior years exclude encephaloceles that are not part of another syndrome. Inclusion of encephaloceles that are not part of another syndrome would increase the 2008 numerator to 44, and the rate to 6.3 per 10,000; the 2007 numerator to 47 and the rate to 6.5 per 10,000; the 2006 numerator to 51 and the rate to 7.2 per 10,000; and the 2005 numerator to 52 and the rate to 7.7 per 10,000.

Denominator:The denominator is a composite that includes all 2008 live births from the Vital Statistics birth statistical master file, and all 2006 fetal deaths from the Vital Statistics fetal death file, excluding military births in the monitored counties. The 2006 fetal death total was used since the 2007 and 2008 fetal death files are currently unavailable for use.

Notes - 2007
Source: State of California, Department of Public Health, California Birth Defects Monitoring Program (CBDMP) Registry, 2007.

Numerator: Confirmed cases of NTDs in 2007 among fetal deaths plus live births in monitored counties (provisional). The provisional data for 2007, as well as all data reported in prior years, include only anencephaly and spina bifida cases. Including encephaloceles that are not part of another syndrome for prior years data would increase the numerators and rates as follows: 2003 = 54 cases, 8.5 per 10,000; 2004 = 40 cases, 6.1 per 10,000; 2005 = 52 cases, 7.7 per 10,000; 2007 = 47 cases, 6.6 per 10,000. Encephalocele data for 2006 are not yet available from CBDMP, and 2006 indicator data reported in the table are still provisional.

Denominator: Fetal deaths plus live births in monitored counties. The number of counties included in the registry was reduced beginning in 1998. Data since 1998 are from eight counties in the Central Valley. Analysis carried out by CBDMP of the neural tube defect incidence data suggest the comparability of the 8-county sample with the larger sample used through 1997. The eight counties are deemed sufficient by CBDMP for surveillance purposes in this state.

a. Last Year's Accomplishments

Between 2001 and 2007, the incidence of neural tube defects, calculated for spina bifida and anencephaly only, has fluctuated between 5.2 and 8.5 per 10,000 (using the corrected number for 2003, as reported in the 2007 Field Note to Form 11). The provisional incidence for 2008 is 5.7 for spina bifida and anencephaly. The HP 2010 target is to reduce the occurrence of spina bifida and other NTDs to 3 new cases per 10,000 live births.

CBDMP expanded reporting of NTDs to include neural-tube-related encephaloceles that are not part of a syndrome (i.e., not part of a syndrome, which has a suite of symptoms, only one of which is an encephalocele) in 2007. The incidence data, provided by CBDMP, are based on eight counties in the Central Valley.

MCAH continues its long-standing efforts to improve folic acid intake before and during pregnancy, since folic acid intake around the time of conception is associated with lower rates of NTDs. MCAH continues to collaborate with and/or provide technical assistance to the LHJs, other CDPH programs and outside groups such as MOD. MCAH programs that promote the folic acid message include: ECCS, CBDMP, CDAPP, CPSP, PHHI, BIH and AFLP. MCAH also encourages CDC, MOD, the National Council on Folic Acid and others to work towards the fortification of corn tortillas with folic acid since Latinas, who have a higher risk for NTDs, tend not to consume the folic acid-fortified grain products currently on the market.

MCAH actively participate on the PHCC which provides information, tools and resources to local communities about the importance of achieving optimal health for women before pregnancy, including adequate folic acid intake, as a means to improving poor birth outcomes such as neural tube defects.

The MCAH website provides information on folic acid needs, sources, recommendations, and resources at http://cdph.ca.gov/folicacid, the California Birth Defects Monitoring Program page http://www.cbdmp.org/sr_folic_acid.htm discusses how research on folic acid led to the prevention of birth defects. The Genetic Disease Screening Branch discusses prenatal screening at http://www.cdph.ca.gov/programs/pns/Pages/default.aspx . Folic acid consumption is one of the key preconception health topics in the PHCC website. This website takes the place of the provider packet Every Woman Every Time, produced by MOD and Sutter Medical Center Sacramento, which was in need of revision.

Following the implementation plan suggested by the Folic Acid stakeholder group, MCAH sponsored a multi-pronged folic acid awareness campaign targeting Latinas of reproductive age in the spring of 2009. This campaign included radio PSAs, mini-dramas and radio talk shows; revised folic acid brochures and posters; development of a training curriculum for health promoters; a small-scale vitamin distribution campaign at selected WIC centers and family planning clinics; and a provider education campaign about folic acid being a covered benefit

under Medi-Cal. The campaign resulted in a 1200% increase in calls to the CDC's referral line and 45,000 bottles of vitamins distributed.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCAH produces and distributes pamphlets, posters, and other educational materials, in Spanish and English, which promote folic acid use among women of reproductive age.			X	
2. MCAH collaborates with and provides technical assistance regarding folic acid use to local programs, including AFLP, BIH, and CPSP; and other programs in CDPH, such as WIC, the Genetic Disease Branch (GDB), and the Champions for Change.			X	
3. Folic acid promotion is undertaken through distribution of the CPSP “Steps to Take” guidelines, CDAPP Guidelines for Care, and AFLP's Nutrition and Physical Activity Guidelines for Adolescents.			X	
4. Information about neural tube defects and folic acid is provided on the websites of MCAH, CDBMP and GDB.			X	
5. MCAH collaborates with national agencies to advocate for the continued fortification of the grain supply.				X
6. MCAH collaborates with organizations and committees to develop strategies for increasing awareness of the importance of folic acid consumption among providers and consumers.		X		
7. MCAH publicizes National Folic Acid Week annually to all MCAH Programs, state nutritionists and CDPH nutrition networks.			X	
8. MCAH continually monitors neural tube defects trends to address the need for prevention efforts and activities.			X	
9. MCAH develops/updates neural tube defects fact sheet to distribute to hospitals and local county health departments.		X		
10.				

b. Current Activities

MCAH sends out information through its networks about National Folic Acid Week. MCAH will continue its efforts to promote folic acid use among women of reproductive age. Folic acid educational materials, including the newly revised pamphlet and poster, will continue to be distributed across the state via local MCAH, OFP, WIC and GDSP as well as by MOD. These resources are also available on MCAH's folic acid website.

The PHCC website includes a section where providers can register as partners, upload materials, participate in discussion forums and share resources. It will include an interactive quiz for consumers so they can gauge their preconception health. The quiz will have a section on folic acid use. MCAH is publicizing the preconception health website to healthcare and public health providers and other agencies and groups across the state who serves women of reproductive age.

MCAH is revising the folic acid components in the CDAPP Guidelines for Care and the Nutrition and Physical Activity Guidelines for AFLP.

MCAH is designing a preconception health social marketing campaign with "First Time Motherhood" grant funds from HRSA/MCHB. One component of the campaign is dissemination of information about folic acid to Latina women of reproductive age in targeted geographic areas

using an original Spanish language musical radio PSA.

c. Plan for the Coming Year
MCAH will continue its efforts to promote folic acid use among women of reproductive age. Folic acid educational materials will continue to be distributed across the state via local MCAH, OFP, WIC and GDSP as well as by MOD. These resources will continue to be available on MCAH's folic acid website and on everywomancalifornia.org. MCAH will continue to encourage LHJs to promote preconception folic acid intake. The First Time Motherhood Spanish language radio PSA will be aired in July 2010. The PSA builds on a classic Latin song with the original lyrics changed to convey a folic acid preconception health message. The PSA will direct listeners to call 211 for more information. The 211 line is staffed by both English and Spanish speaking operators who will be trained to answer questions about folic acid, 24 hours per day, seven days per week. The campaign will be reinforced at the community level through the local MCAH programs, WIC and the statewide health promoter network, Vision Y Compromiso.

MCAH will monitor the 2009 and 2010 data from CWHS to see whether women of reproductive age have heard about folic acid and if so where and by who. Additionally, we will monitor in the 2009 and 2010 MIHA survey results for frequency of preconception intake of a multivitamin, prenatal vitamin or folic acid vitamins.

State Performance Measure 7: *The percent of newly referred clients to the CCS program whose cases are opened within 30 days of referral.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		76	72	77	82
Annual Indicator	75.7	70.4	76.2	81.1	78.4
Numerator	20638	34053	37977	43201	41903
Denominator	27269	48387	49871	53263	53455
Data Source				CMS Net and LA County	CMS Net and LA County
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	83	84	85	86	

Notes - 2009
This measure is the percent of newly referred clients to the CCS program whose cases are opened within 30 days of referral.

The data are CMS Net data for 57 counties and data from LA County for FY 2008-09. The 57 counties opened 78 percent of their cases within 30 days of referral and LA County opened 99 percent of their cases within 30 days of referral.

The percent is lower for 2008-09 due to staffing cuts resulting in caseload backlogs.

This is the final year for reporting on this measure.

Notes - 2008

This measure is the percent of newly referred clients to the CCS program whose cases are opened within 30 days of referral.

The data are CMS Net data for 57 counties and data from LA County for FY 2007-08. The 57 counties opened 76 percent of their cases within 30 days of referral and LA County opened 97.3 percent of their cases within 30 days of referral.

Notes - 2007
This measure is the percent of newly referred clients to the CCS program whose cases are opened within 30 days of referral.

The data are CMS Net data for 56 counties and data from LA County for FY 2006-07. Sacramento is not collecting comparable data and so it is not included in this measure.

a. Last Year's Accomplishments
SPM 07 was a new California SPM in 2006. In FY 08-09 the percent of referrals opened within 30 days is 78 percent compared to 81.1 percent for FY 07-08. It is believed that the decrease in this annual indicator is due to staffing cuts. The local CCS offices have developed a process to prioritize referrals identified as "expedite". The delay in accessing needed services continues to be an issue for families.

Decreasing the time interval between referral to the CCS program and receipt of CCS services was identified as one of the top ten state priorities during the five year needs assessment. Families and providers have repeatedly identified long intervals of time from referral to CCS to authorization of services as a barrier to accessing needed services and as a source of frustration. There is no single reason for delays in opening newly referred cases, but through this measure, the CCS program has been identifying areas in the process of determining program eligibility and implementing process improvements that are increasing the percentage of cases opened within 30 days of referral.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CCS will identify areas for improvement in the eligibility determination as staffing allows.		X		
2. CCS will identify factors influencing the length of time from CCS referral to authorization and to receipt of services as staffing allows.		X		
3. Strategies to reduce the referral process is to station CCS workers in hospitals as staffing allows.				X
4. Facilitating provision of medical and financial information from families and providers to expedite eligibility determinations and service authorizations as staffing allows.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
CCS workers continue to be stationed in hospitals, when and where the budget allows, to streamline the referral process. Exemptions to fill vacant positions to process referral

authorizations are requested. Referrals identified as "expedite" are prioritized. Plans to redesign the referral process are on hold due to the staffing shortage.

c. Plan for the Coming Year
CMS will continue to station CCS workers in hospitals when and where the budget allows to streamline the referral process. CMS will try to fill vacant positions to process referral authorizations, and prioritize referrals identified as "expedite."

There will be further discussions with counties that have the shortest interval between their new referrals and opening a case within 30 days, in order to determine their "best practices" that could be applied to the remaining counties.

The effectiveness of CCS workers stationed in hospitals to improve the referral process and decrease the time interval between CCS referral and receipt of CCS services will be evaluated.

Continuing analysis of cases that take longer than 30 days to open will identify reasons for delays and what actions, if any, could be taken to improve upon delays. A tool will be developed so that county and regional office programs can randomly audit cases opened after 30 days, categorize reasons for delays, and initiate possible interventions.

State Performance Measure 8: *The percent of births resulting from an unintended pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		42.1	40.9	40.5	40.1
Annual Indicator	41.3	43.2	44.6	45.4	45.4
Numerator	222148	239285	247549	243136	
Denominator	537394	554168	555219	535094	
Data Source				MIHA, 2008	MIHA
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	39.7	39.3	39.3	39.3	

Notes - 2009
A manual indicator is reported for 2009 based on 2008.

Notes - 2008
Source: 2008 Maternal and Infant Health Assessment (MIHA) survey, MCAH Division, California Department of Public Health.

Numerator: Number of women with a live birth who scored 0-9 on the London Measure of Unplanned Pregnancy (LMUP)* among women who responded to all six items of this measure. In 2008, the LMUP* replaced the single question used in previous years to measure pregnancy intention.

Denominator: Number of women delivering a live birth who responded to all six LMUP* items or scored 10 without responding to one of the items.

Numerator and denominator are weighted to the representative number of California resident

women 15 years of age and older who delivered a live birth that year. Because of the new measure of pregnancy intention in 2008, the 2008 indicator value cannot be compared with those of previous years.

Notes - 2007
Source: 2007 Maternal and Infant Health Assessment Survey, MCAH Program, California Department of Public Health.

Numerator: Number of women who delivered a live birth who reported that they had wanted to get pregnant later, hadn't wanted to get pregnant then or in the future, or weren't sure what they wanted.

Denominator: Number of women who delivered a live birth who reported when they had wanted to get pregnant.

Numerator and denominator are weighted to the representative number of resident women in the state who delivered a live birth that year.

a. Last Year's Accomplishments
The proportion of births resulting from an unintended pregnancy has been collected via California's MIHA (an annual, population-based survey modeled on PRAMS) since 1999.

The 2008 proportion cannot be compared with proportions from earlier years because of the change to using the six-item London Measure of Unplanned Pregnancy (see 2008 note above) in place of the previous single-item measure. The proportion of unintended pregnancies among women giving birth in California had been steadily declining from 1999 (estimated at 49%), through 2005. By comparison, in 2002 (the most recent year for which data are available), 35% of recent births in the United States were unintended.[8]

There are notable disparities by race/ethnicity. The proportion of unintended pregnancy among women giving birth in California in 2008 was highest for African-American women (69.0%), compared to 52.4% for Hispanic women, 36.4% for Asian/Pacific Islander women and 33.5% for White women. Data for the United States suggests that the differences between African-American and other women are somewhat larger in California than in the nation as a whole. In 2002, 51% of recent births to African-American women in the U.S. resulted from unintended pregnancy, compared to 44% of births to Hispanic women and 29% of births to White women.[40]
Unintended pregnancy rates are highest for adolescents. Adverse consequences of unintended pregnancy are more severe for teens than for adults, and may include lower educational prospects and a greater risk of living in poverty. Adverse consequences of unintended pregnancy for women of any age and their babies include: the lost opportunity to receive preconception counseling to improve the health of the fetus (such as by increasing folic acid intake or controlling diabetes prior to pregnancy); less likely to receive early or adequate prenatal care, more likely to smoke or drink during pregnancy, and more likely to have low birth-weight babies. [41] Costs to society include increased health care and welfare expenditures and increased risk of child abuse and neglect.[42]

MCAH and OFP support programs that help women avoid unintended pregnancy by decreasing risky behavior, increasing access to and promoting the use of effective contraceptive methods, and improving the effectiveness with which all methods are used. OFP programs include Family PACT; the Community Challenge Grant Program (CCG) and the Information and Education Program (I&E). California's 2008/09 Budget Act eliminated the Male Involvement Program (MIP) and the TeenSMART Outreach program. MCAH programs include AFLP, BIH and PHHI. During fiscal year 2008-2009, 126 agencies provided over 215,500 teen and parent participants with pregnancy prevention education training through I&E.
MCAH actively participated on the PHCC which plays a pivotal role in relaying the message of the importance of reproductive life planning, pregnancy intendedness and preconception care to local

communities. In May 2009 PHCC launched a comprehensive preconception health website with resources for consumers and providers. Reproductive life planning (RLP), which aims to help women avoid unintended pregnancy and achieve optimal pregnancy spacing, is included as one of the key components.

MCAH participated in ASHWG, a collaborative effort between CDPH, CDE, and key non-governmental organizations. ASHWG works to create a coordinated, collaborative, and integrated system to promote and protect the sexual and reproductive health of California youth, including ensuring access to family planning services in order to reduce the rate of unintended pregnancy.

ASHWG developed core competencies for providers of adolescent sexual and reproductive health services and completed the first stage of a data integration that presents data about STDs, HIV and teen birth rates in a uniform format for better comparison across indicators and to facilitate the development of coordinated interventions. MCAH presented on ASHWG's Data Integration Project and use of data to inform work on health disparities at the Association of Maternal and Child Health Programs' (AMCHP's) annual conference.

MCAH produced a Teen Birth Rate Resource with maps and tables of teen birth rates by race/ethnicity and geographic area, for targeting of teen pregnancy prevention efforts. The information was distributed to targeted stakeholders and made available on the MCAH website.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The MCAH and OFP Divisions support several programs that help women avoid unintended pregnancy by decreasing risky behavior and increasing access to and promoting the use of effective contraceptive methods.				X
2. The Family PACT Program provides family planning services, testing and treatment of sexually transmitted diseases, and education and counseling to low-income Californians.	X			
3. The Information and Education Program (I&E) provides pregnancy prevention training and referrals to adolescents .		X		
4. The Community Challenge Grant (CCG) program promotes community-based partnerships to develop effective local teen pregnancy prevention programs and to promote responsible parenting.				X
5. The Adolescent Family Life Program (AFLP) utilizes a case management and mentoring model to assess and address the risks and resources of adolescent clients and their children, including prevention of subsequent pregnancies.		X		
6. The Black Infant Health Program (BIH) incorporates discussion of contraception and pregnancy spacing into its case management, group sessions and health promotion activities.		X		
7. The Preconception Health and Health Care Initiative (PHHI) supports organizations to prevent unintended pregnancy and improve preconception health by providing best practices and networking opportunities.				X
8. ASHWG works to promote and protect the sexual and reproductive health of California youth, which includes a focus on pregnancy prevention.				X
9.				
10.				

b. Current Activities
The Family PACT Program serves approximately 1.7 million clients per year, including about 350,000 adolescents. Family PACT undertakes ongoing efforts in the areas of client outreach; provider recruitment, training, and technical assistance; and the addition of new Food and Drug Administration-approved contraceptive methods to the benefits package. The CCG and I&E Programs continue to reach teens with pregnancy prevention information and referrals.

AFLP provides services to about 17,000 teens a year.

MCAH is incorporating the concept of RLP into the revised BIH model. MCAH is developing user-friendly RLP tools for consumers and providers. Focus groups were held with women of varying ages and backgrounds to inform the development of these tools. MCAH presented on the concept of RLP for adolescents at the Teen Now conference in September 2009.

Through its involvement with the CFHC project to integrate preconception/interconception health and RLP messages into Title X-funded clinics, the PHCC is marketing its website to family planning and women's health care providers, as well as other agencies and groups across the state who serve women of reproductive age.

c. Plan for the Coming Year
In spite of the success in recent years in reducing the proportion of births that result from an unplanned pregnancy, prevention of unintended pregnancy will continue to be a major issue for California. It is projected that Hispanics will become the largest race/ethnic group in California by the year 2011. The high birth rates for Hispanic women and the high proportion of their births that are unintended at the time of conception suggest that this demographic trend will put upward pressure on the overall proportion of births that are unintended.

Family PACT, CCG, I&E, and AFLP will continue their teen pregnancy prevention efforts. The revised BIH model and group curriculum will be piloted this year. The curriculum consists of ten group sessions during the prenatal period and ten group sessions postpartum. Several of the postpartum sessions will address the issue of birth spacing and the importance of planning for a subsequent pregnancy to ensure the best outcome for mother and baby. During the final session participants will create a life plan that will include plans for future children and decisions about birth control methods.

The Family PACT Medicaid Demonstration Project Section 1115 Waiver has been extended by the Centers for Medicare and Medicaid Services through 6/30/10 to continue negotiations of the State's renewal application and the Special Terms and Conditions of the Waiver.
MCAH will continue participation on ASHWG and will be expanding data integration to include behavioral data from CDE and other sources. In addition, a youth development framework to guide ASHWG member activities will be developed. Activities to promote core competencies for providers of adolescent sexual and reproductive health will include development of human resources and training tools. Lastly, a matrix will be developed to assess reproductive health curricula based on level of evidence, youth developed principles, and adherence to California HIV education and comprehensive sex education legal requirements.

The PHCC will continue to work with its partners on the development of tools and messaging about reproductive life planning and will feature materials and best practices on its website.

MCAH will implement a preconception health social marketing campaign funded by a First Time Motherhood grant from HRSA/MCHB. The campaign will have three separate components: one targeting African-American women; one targeting Latina women and one targeting youth of color. The African-American and youth components will feature messaging encouraging women to plan for pregnancy in order to ensure the best outcome for themselves and any children they may have. The messaging campaigns will use both traditional and innovative message delivery

mechanisms including text messaging and social networking sites.

State Performance Measure 9: *The percent of 9th grade students who are not within the Healthy Fitness Zone for Body Composition.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		32.8	32.9	32.7	32.5
Annual Indicator	33.1	32.0	31.3	30.3	30.3
Numerator	147308	144156	140123	139081	
Denominator	445038	450488	447676	459013	
Data Source				CA Dept of Education, 2008	CA Dept of Education
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	32.3	32.1	31.9	31.7	

Notes - 2009
A manual indicator is reported for 2009 based on 2008.

Notes - 2008
Source: California Department of Education. 2008 California Physical Fitness Testing (PFT) Results available at http://www.cde.ca.gov/ta/tg/pf/pftresults.asp (Accessed on 6/14/2010).

Numerator: The number of 9th grade students whose body composition is not within the Healthy Fitness Zone.

Denominator: The number of 9th grade students tested for body composition.

Note: The denominator and percent of 9th grade students not within the healthy fitness zone for body composition were available from the report. The numerator was calculated by multiplying the denominator by the percent.

Notes - 2007
Source: California Department of Education. 2007 California Physical Fitness Test Results, accessed on 1/14/09 at http://data1.cde.ca.gov/dataquest/PhysFitness/PFTestSt2007.asp?cYear=2006-07&cChoice=PFTest1&RptNumber=0.
A summary report, 2007 California Physical Fitness Testing: Report to the Governor and the Legislature, is available at http://www.cde.ca.gov/ta/tg/pf/documents/reporttogov.pdf. Accessed 1/14/2009.

Numerator: The number of 9th grade students whose body composition is not within the Healthy Fitness Zone. Denominator: The number of 9th grade students tested for body composition. Note: The denominator and percent of 9th grade students not within the healthy fitness zone for body composition were available from the report. The numerator was calculated by multiplying the denominator by the percent.

a. Last Year's Accomplishments

The 2008 data reflect the steady decrease of 9th grade students whose body composition in not within the Healthy Fitness Zone. This rate was 33.1% in 2005, 32.0% in 2006, 31.3% in 2007, and 30.3% in 2008. By gender, the rate for female students is lower compared to male students (28.8% compared to 31.7%) within the category "not in the Healthy Fitness Zone". In terms of racial/ethnic groups, Asians had the lowest rate at 17.4% followed by students who were White (21.8%) and Filipino (24.3). At the other end of the spectrum, students who were Hispanic had the highest rate (37.4%), followed by African-American (33.9%) and American Indian (34.8%).

MCAH and CMS were involved with strategic planning for the CDC-funded California obesity prevention initiative entitled Nutrition, PAOPP. In addition, MCAH and CMS actively participated in the CDPH OPG the Inter-Agency Nutrition Coordinating Council and the CMS-MCAH-WIC and GDSP Nutrition Coordinating Committee. All of these collaboratives support and promulgate messages supporting 9th graders health through increased physical activity and optimal nutrition.

MCAH and CMS participated in the planning of the 2009 Childhood Obesity Conference held in Anaheim, California. The conference built upon the past four conferences by promoting collaboration, showcasing evidence-based prevention interventions, accelerating the obesity prevention movement, and featuring community efforts. MCAH was also on the planning committee for the2009 Weight of the Nation, a forum to highlight progress in the prevention and control of obesity through policy and environmental strategies and is framed around four intervention settings: community, medical care, school, and workplace.

The majority of the MCAH LHJs reported that they are working to promote nutrition and physical activity to address the obesity epidemic. LHJs provided outreach, education and guidance to families related to appropriate diet and exercise. Inter and intra county coalitions were established to plan and implement programs designed to reduce obesity within the school age population, such as introducing healthy food choices into school cafeterias and increase opportunities for physical activities in the school curricula. LHJs continued to participate in First Five funded councils and activities, evaluate local childhood obesity data and share with health care and public health workers through mapping and reports, develop and implement county nutrition plans, support school health including walk to school, provide community nutrition and physical activity classes, including utilizing the National Office of Women's Health BodyWorks curriculum for parents of tweens, participate in Healthy Eating and Living Collaboratives, use media to promulgate messages, and collaborate with other programs serving families and children.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. MCAH and CMS participate in the CDPH Obesity Prevention Group, the Inter-Agency Nutrition Coordinating Council, and the Center for Family Health Nutrition Coordinating Committee.				X
2. MCAH and CMS have been involved with program planning, implementation and evaluation in the CDC funded Nutrition, Physical Activity and Obesity Prevention Program.				X
3. The AFLP and BIH Programs promote healthy food choices and physical activity by distributing nutrition and physical activity guidelines and holding discussions on how to cut fat and lower calories		X		
4. CMS collects data from CHDP nutrition assessments by CHDP providers for infants, children, and adolescents and forwards the data to CDC for entry into PedNSS.				X
5. MCAH LHJs work with school districts to introduce healthy food choices into school cafeterias and increase opportunities for physical activities in the school curricula.		X		

6. MCAH develops and/or provides nutrition education materials and initiatives, nutrition assessment materials, technical assistance and consultation, and funding opportunities to MCAH programs and colleagues.				X
7. MCAH and CMS participate in planning bi-annual Childhood Obesity Conferences.				X
8.				
9.				
10.				

b. Current Activities
MCAH provides nutrition and physical activity resources, intervention ideas, and training opportunities to LHJs and other colleagues. MCAH and CMS will continue to promote healthy lifestyles that include increasing physical activity, reducing television viewing, and consuming five to nine fruits and vegetable servings per day. AFLP continues to promote healthy food choices and physical activity through promotion of nutrition and physical activity guidelines and a cookbook which is targeted to teens. MCAH is editing changes to the Adolescent Nutrition and Physical Activity Guidelines, science based guidelines with culturally competent recommendations. PHCC is marketing new ACOG and MOD provider guidelines for the post-partum visit, which will include guidance to providers for the interconception management of women who developed gestational diabetes during their prior pregnancy.

MCAH and CMS are collaborating with other state programs, agencies, advocates, experts and local MCAH directors to prevent and address tween and teen overweight. MCAH and CMS continue to participate on the OPG, which aims to integrate obesity prevention into CDPH programs. MCAH and CMS are participating in the planning of the 2011 Childhood Obesity Conference and continue collaboration with the CDC-funded California Nutrition, PAOPP.

c. Plan for the Coming Year
Existing MCAH and CMS programs will continue to promote healthy lifestyles that include increasing physical activity, reducing television viewing, and consuming five fruits and vegetable servings per day. MCAH and CMS will continue to actively participate in coalitions and committees to promote nutrition and activity. MCAH and CMS will continue to participate on the Obesity Prevention Group which aims to integrate obesity prevention into CDPH programs.

MCAH will continue to provide nutrition and physical activity resources and intervention ideas to LHJs and colleagues. LHJs will continue to support local obesity-related coalitions, participate in First Five funded councils and activities, evaluate local childhood obesity data and share with health care and public health workers through mapping and reports, develop and implement county nutrition plans, support school health including walk to school, provide community nutrition and physical activity classes, participate in Healthy Eating and Living Collaboratives, use media to promulgate messages, and collaborate with other programs serving families and children.

AFLP will continue to promote healthy food choices and physical activity through finalization and distribution of nutrition and physical activity guidelines and a cookbook which is targeted to teens. Updates will include new science based guidelines and culturally competent recommendations. The adolescent cookbook will contain options for physical activity and substituting seasonal fruits and vegetables.

PHHI will continue its collaborations with organizations and programs that reach adolescents with information about healthy eating and active living.

MCAH and CMS will work on the next Childhood Obesity Conference scheduled for June 2011 in San Diego, California. The conference tracks include: Healthcare, Early Childhood, Schools/After

School, Marketing, Community, and Research. All tracks will integrate the following strategies: Environmental and policy change, Built environment/land use and transportation planning, Civic engagement, Community food systems and rural development, Family-based approaches, Health equity, Program implementation during a tight economy, Safety, Low income, Balance of nutrition/physical activity, and National speakers and programs.

State Performance Measure 10: *The percent of women, aged 18 years or older, reporting intimate partner physical, sexual or psychological abuse in the past 12 months.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		9.6	8.4	8.3	8.2
Annual Indicator	8.5	7.6	7.7	6.3	6.3
Numerator	896672	856984	861184	640974	
Denominator	10549890	11298656	11199170	10216673	
Data Source				CWHS, 2008	CWHS
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	8.1	8	7.9	7.9	

Notes - 2009
A manual indicator is reported for 2009 based on 2008.

Notes - 2008
Source: California Department of Public Health, California Women's Health Survey (CWHS), 2008.

Numerator: Number of women (18 years old or older) reporting any intimate partner physical, sexual, or psychological/emotional abuse in the past 12 months.

Denominator: Number of women (18 years old or older) completing at least one of a series of nine questions in the CWHS on intimate partner abuse. Results are weighted using the California Department of Finance population data for 2000 (file name Race/Ethnic Population with Age and Sex Detail, 2000-2050).

Data prior to 2006 are not comparable.
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Notes - 2007
Sources: California Department of Public Health, California Women's Health Survey (CWHS), 2007. Numerator: Number of women (18 years old or older) reporting any intimate partner physical, sexual, or psychological/emotional abuse in the past 12 months. Denominator: Number of women (18 years old or older) completing at least one of a series of nine questions in the CWHS on intimate partner abuse. Results are weighted using the California Department of Finance population data for 2000 (file name Race/Ethnic Population with Age and Sex Detail, 2000-2050), May 2004.

2006-07 data should not be compared to prior year data. Beginning in 2006, women without intimate partners are included in the denominator. Recalculated rates for prior year data using this method: 2005 = 8.1%; 2004 = 9.2%; 2003 = 8.3%.

a. Last Year's Accomplishments

Through June 2009, OFP funded 94 DV shelter agencies to provide emergency and non-emergency services to victims of domestic violence. Over 100,000 victims and their children received emergency shelter, legal assistance with restraining orders, transitional housing, or other support services in 2008. Additionally, OFP administered a major Training and Technical Assistance Project to build shelter agencies' capacity to serve particular unserved and underserved populations; namely, disabled and developmentally disabled persons, persons with mental health or substance abuse issues, and lesbian, gay, bisexual, transgendered and questioning (LGBTQ) clients. The project involved needs assessments for the 94 shelter agencies, training in 5 geographic regions throughout the state, and technical assistance to implement change using continuous quality improvement. The project ended June 30, 2009.

Project accomplishments included:

- 94.5% of shelter agencies indicated increases in staff knowledge of mental health issues.
- 91.4% of shelter agencies indicated increases in staff knowledge of substance abuse issues.
- 77.1% of shelter agencies reported applying knowledge and awareness in agencies' practices with LGBTQ clients.
- 75% of shelter agencies reported staff developed a more empathic understanding and increased commitment to working with LGBTQ clients.
- The percentage of agencies with protocols for services to persons with disabilities increased from 28.7% to 84% by project end.
- 33% of agencies made physical/structural modification to increase shelter and services access for disabled clients.

The DV Training and Education Program within the Center for Chronic Disease and Injury Control; SAC Branch:

- Launched their "Domestic Violence Advocates and Faith and Spiritual Leaders: Collaborative for Community Change" initiative to provide small grants to change practices and attitudes to prevent violence against women in the faith community.
- SAC also provided 6 technical assistance and training grants to local organizations to conduct DV prevention programs and updated their web-based Violence Prevention Resource Directory.
- Created the Teen Dating Violence Prevention Team, to inventory existing data sets on Teen Dating Violence.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Identify maternal deaths due to violent injury.			X	
2. Provide DV shelter services for victims of DV and their families.	X			
3. Outreach to faith and spiritual community leaders to change practices and attitudes regarding violence against women to a more prevention focus		X		
4. Provide technical assistance grants to local organizations to build local capacity in DV primary prevention.		X		X
5. Maintain a Violence Prevention Resource Directory with county-specific contact information for DV agencies and providers.		X		
6. Conduct an environmental scan of Teen Dating Violence resources and activities within the state.				X
7.				

8.				
9.				
10.				

b. Current Activities
The Pregnancy --Related and Pregnancy- Associated Mortality Review (PAMR) project in MCAH uses enhanced surveillance strategies to identify all maternal deaths while pregnant or within one year of delivery. Of 388 deaths in the 2002-2003 cohort for which review was completed this year, 90 were directly related to complications of pregnancy and 298 deaths appeared not related to complications of pregnancy. Violent injuries (homicide and suicide) were the second leading cause of death among the group of not-pregnancy-related cases. This is a noteworthy category for further data collection and analysis.

SAC activities include continued administration of DV/Faith mini-grants; technical and training assistance grants and updates of the Resource Directory. The Teen Dating Violence program is conducting an environmental scan of Teen Dating Violence prevention activities in the state and developing a plan to coordinate prevention efforts.

The California Emergency Management Agency, Public Safety and Victim Services Programs Division, launched a Children Exposed to Domestic Violence Specialized Response Program RFA for FY 2010/2011. The grant period began January 1, 2010 and ends December 31, 2010. The total amount available for the DV Program is $400,000. These funds are made available through the federal Children's Justice Act funds.

c. Plan for the Coming Year
PAMR will reach out to other programs that collect information that could be valuable for understanding violent maternal deaths, as it is believed many of these will be DV homicides. When California started the Electronic Death Registration System in 2005, a violent death supplement was added to death certificates which capture information from coroners on violent deaths. Since homicide is one of the leading causes of death of pregnant or recently pregnant women, examining this data, perhaps in combination with case review by local DV Fatality Review Teams, will provide more information about violent deaths in pregnancy.

The DV Training and Education Programs within SAC will continue to administer DV/Faith mini-grants, technical and training assistance grants and updates of the Resource Directory. The Teen Dating Violence program will disseminate the "Coordination Plan" and "Recommendations for Teen Dating Violence Prevention" targeting urban youth.

E. Health Status Indicators

Introduction
California utilizes various data sources to complete the indicator data for the various health status indicators (HSI). These include the Birth Statistical Master file (HSI 1, 2 and 7), the Death Statistical Master file (HSI 3 and 8) the Patient Discharge Data from OSHPD (HSI 4), the STD Surveillance report (HSI 5), the Race/Ethnic Population Projection with Age and Sex Detail from the Department of Finance(HSI 6) and the Annual Social and Economic Supplement, Current Population Survey from the U.S. Census Bureau (HSI 11 and 12).

A composite of data gathered from the (1) Race/Ethnic Population Projection with Age and Sex Detail from the Department of Finance, (2) the Annual Social and Economic Supplement, Current

Population Survey from the U.S. Census Bureau, (3) the Federal Data Reporting and Analysis Bureau of DSS, (4) MediCal Care statistics from DHCS, (5) the HF Program Monthly Enrollment Reports from MRMIB, (6) WIC data from the WIC, (7) Juvenile Arrests reported by the Criminal Justice Center of the Department of Justice, and (8) Number of Dropouts from California Public Schools from CDE are used to complete the indicators for HSI9.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	6.9	6.9	6.9	6.8	6.8
Numerator	37653	38517	38918	37663	
Denominator	548679	562135	566079	551550	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
A manual indicator is reported for 2009 based on 2008.

Notes - 2008
Source: State of California, Department of Public Health, Center for Health Statistics, 2008 California Birth Statistical Master File.

Tabulations (by place of residence) were done by the MCAH Program. Cases with missing birthweight were excluded from the denominator.

Notes - 2007
Source: State of California, Department of Public Health, Center for Health Statistics, 2007 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program. Cases with missing birthweight were excluded from the denominator.

Narrative:
In 2008, the percent of live births weighing less than 2,500 grams was at 6.8 percent. Whites and Hispanics have had the lowest rates over the past five years. In 2008, 6.1 percent of Hispanic infants and 6.4 percent of White infants were LBW. The rate is highest among Asians and Native Americans at 7.8 and 7.6 percent, respectively. For 2008, the rate for Pacific Islanders was at 6.8 percent.

MCAH engages in numerous efforts to understand the risks and optimize outcomes for LBW infants. Through its support of CPQCC and CMQCC, MCAH works to improve neonatal and maternal outcomes with primary data collection, evaluation, and hospital/provider-based QI policies and projects. Best practices and strategies for addressing risk factors are developed and made available to neonatal/pediatric and obstetric providers, such as those found in the Care and Management of the Late Preterm Infant Toolkit and the < 39 Weeks Toolkit (the purpose of which is to eliminate <39 weeks elective delivery in California).

Moderately low birth weight (MLBW), between 1,500 to 2,499 grams, is most commonly

associated with intrauterine growth restriction and/or delivery between 34 and 37 weeks gestation (called Late Preterm Infants). Late preterm delivery is associated with factors such as: multi-fetal pregnancies, maternal age less than 17 years, perinatal factors such as pre-eclampsia, over- and underweight gain in pregnancy, induction and augmentation of labor, and Cesarean delivery. MLBW infants experience increased risk for complications such as hyperbilirubinemia, Respiratory Distress Syndrome, suspected sepsis and feeding difficulties. MCAH works closely with the MOD, California Chapter on the Prematurity Campaign to prevent LBW babies.

BIH works with African American mothers to optimize their pregnancy outcomes. Other MCAH partners involved in these efforts include the Premature Infant Health Coalition, CCS, California Association of Neonatologists, RPPC, CPeTS, CDAPP and PAMR.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	5.2	5.2	5.3	5.2	5.2
Numerator	27796	28595	28975	27948	
Denominator	531377	544762	548564	534215	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
A manual indicator is reported for 2009 based on 2008.

Notes - 2008
Source: State of California, Department of Public Health, Center for Health Statistics, 2008 California Birth Statistical Master File.

Tabulations (by place of residence) were done by the MCAH Program. Cases with missing birth weight were excluded from the denominator.

Notes - 2007
Source: State of California, Department of Public Health, Center for Health Statistics, 2007 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program. Cases with missing birth weight were excluded from the denominator.

Narrative:
The percent of live singleton births which were LBW for 2008 was 5.2 and remain relatively unchanged since 2004. Racial and ethnic rate differences for LBW singleton births are similar to those seen for all LBW births. For 2008, it was highest among African American infants at 10.1 percent compared to infants who were Native American (6.2 percent), Asian (6.1 percent) , Pacific Islanders (5.2 percent), Hispanic (5.0 percent) and White (4.2 percent).

BIH, among other MCAH efforts, addresses disparities in birth outcomes between African Americans and other racial/ethnic groups. The program provides African American women, their

families and communities with services addressing factors that negatively impact birth outcomes. Strategies to prevent prematurity and reduce LBW include culturally competent approaches to increasing timely and adequate use of prenatal care, educating women to modify behaviors that may promote preterm labor, smoking cessation and educating women on recognition of the signs of preterm labor.

Efforts to prevent prematurity include those discussed above in HSI 1a. Emphasis on improved pre-pregnancy health and wellness and the provision of preconception health education and access to preconception care are vital to these efforts.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.2	1.2	1.2	1.1	1.1
Numerator	6790	6693	6805	6298	
Denominator	548679	562135	566079	551550	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
A manual indicator is reported for 2009 based on 2008.

Notes - 2008
Source: State of California, Department of Public Health, Center for Health Statistics, 2008 California Birth Statistical Master File.

Tabulations (by place of residence) were done by the MCAH Program. Cases with missing birth weight were excluded from the denominator.

Notes - 2007
Source: State of California, Department of Public Health, Center for Health Statistics, 2007 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program. Cases with missing birth weight were excluded from the denominator.

Narrative:
Births less than 1500 grams are classified as VLBW. The percent of live births which were VLBW in 2008 was 1.1 percent; the first time the rate has changed which was held constant at 1.2 in the past five years. This is slightly higher than the Healthy People 2010 goal of 0.9 percent.

Among racial and ethnic groups, African Americans were twice as likely to give birth to VLBW infants. In 2008, 2.7 percent of African American live births were VLBW. After having risen to 3.0 percent in 2005, this proportion has decreased back to the same level it was six years ago (2.7 percent in 2003). Comparatively, all other racial and ethnic groups were generally between 1.0 and 1.5 percent from 2003-2008.

VLBW is almost exclusively related to prematurity with gestational age of less than 32 weeks.

While not all causes of severe prematurity are well understood, women who have had previous preterm births, are carrying multi-fetal pregnancies, are African American, or are at the extremes of maternal age, have a well-documented risk of preterm delivery. Pre-existing medical conditions and lifestyle issues as seen in the MLBW population also play a significant role in increasing risk.

VLBW infants are at significantly increased risk of infant mortality--nearly 105 times greater than infants born at normal birth weight. Morbidities associated with VLBW include Respiratory Distress Syndrome, intraventricular hemorrhage, patent ductus arteriosus, necrotizing enterocolitis and retinopathy of prematurity. Efforts to prevent severe prematurity include those discussed above in 1a. Emphasis on improved prepregnancy health and the provision of preconception health education and access to preconception care are vital to these efforts.

Optimizing the outcome of VLBW infants requires improvement of risk-appropriate maternal-fetal care. To evaluate variation, understand related issues and provide information on mortality rates within California, MCAH funds several data projects. Perinatal Profiles of California, based at the School of Public Health, University of California, Berkeley, is a risk-adjusted mortality database that reports on sentinel events such as the proportion of VLBW infants born outside of tertiary care facilities. IPODR is a web-based database allowing evaluation of perinatal outcomes at the county and zip code levels.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	0.9	0.9	0.9	0.9	0.9
Numerator	4920	4900	4983	4695	
Denominator	531377	544762	548564	534215	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
A manual indicator is reported for 2009 based on 2008.

Notes - 2008
Source: State of California, Department of Public Health, Center for Health Statistics, 2008 California Birth Statistical Master File.

Tabulations (by place of residence) were done by the MCAH Program. Cases with missing birth weight were excluded from the denominator.

Notes - 2007
Source: State of California, Department of Public Health, Center for Health Statistics, 2007 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program. Cases with missing birth weight were excluded from the denominator.

Narrative:

In 2008 the percent of live singleton births which were VLBW was 0.9 percent which remained constant over the past five years. In 2008, 2.2 percent of African American live singleton births were VLBW a slight increase from 2007 (2.1 percent). Comparatively, 1.4 percent of American Indian singleton births were VLBW in 2008 while Pacific Islanders had 1.0 percent. Rates for Hispanic, Asians, and Whites were between 0.6 and 0.9 percent.

Among racial and ethnic groups, African American singleton infants are the most likely to be VLBW. BIH addresses disparities in birth outcomes between African Americans and other racial/ethnic groups. The program provides African American women, their families and communities with services addressing factors that negatively impact birth outcomes. Strategies to prevent prematurity and reduce LBW include culturally competent approaches to increasing timely and adequate use of prenatal care, educating women to modify behaviors that may promote preterm labor, and educating women on recognition of the signs of preterm labor.

Efforts to prevent severe prematurity include those discussed above in 1a. Emphasis on improved pre-pregnancy health and wellness by providing preconception health education and access to preconception care are vital to these efforts.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	6.4	5.5	5.3	4.2	4.2
Numerator	511	453	436	344	
Denominator	7930829	8228513	8200066	8184698	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
A manual indicator is reported for 2009 based on 2008.

Notes - 2008
Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2008 Death Statistical Master File (ICD-10 Group Cause of Death Codes 295-330).

Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007. Tabulations (by place of residence) were done by the MCAH Program.

Data for 2006-2008 should be not compared to data reported in previous years due to updates in the 2000-2050 population projections released by the California Department of Finance (July 2007). Rates for prior years using these updated population estimates: 2000 = 6.9; 2001 = 6.2; 2002 = 5.8; 2003 = 6.0; 2004 = 5.6; 2005 = 6.2.

Notes - 2007

Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2007 Death Statistical Master File (ICD-10 Group Cause of Death Codes 295-330). Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007. Tabulations (by place of residence) were done by the MCAH Program.

Data for 2006-2007 should be not compared to data reported in previous years due to recent updates in the 2000-2050 population projections released by the California Department of Finance (July 2007). Rates for prior years using these updated population estimates: 2000 = 6.9; 2001 = 6.2; 2002 = 5.8; 2003 = 6.0; 2004 = 5.6; 2005 = 6.2.

Narrative:
Unintentional injury is the leading cause of death in children under aged 1 through 14. In 2008, the death rate due to unintentional injuries among children aged 0-14 was 4.2 per 100,000. This was a marked decrease from 2007. The death rate from fatal accidental/unintentional injuries to children aged 0-14 has shown a continuous decline over the past five years and the 2008 rate is the lowest observed.

This indicator enables the California to identify trends, focus its prevention efforts and determine the success of these efforts. As resources allow, local MCAH programs address childhood injuries. SAC has statewide data systems that track childhood injuries, and makes grants to LHJs using funds from the Kids Plates program to increase the capacity of local organizations statewide to prevent childhood unintentional injuries (e.g., traumatic brain injury, drowning, and burns).

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	3.2	2.6	2.3	1.7	1.7
Numerator	257	218	191	143	
Denominator	7930829	8228513	8200066	8184698	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
A manual indicator is reported for 2009 based on 2008.

Notes - 2008
Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2008 California Death Statistical Master File [The ICD-10 codes for fatal MV traffic injuries are: V30-V79(.4-.9), V81.1, V82.1, V83-V86(.0-.3), V20-V28(.3-.9), V29(.4-.9), V12-V14 (.3-.9), V19(.4-.6), V02-V04 (.1,.9), V09.2, V80(.3-.5), V87(.0-.8), V89.2].

Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California. July 2007. Tabulations (by place of residence) were done by the MCAH Program.

Data for 2007 and 2008 should be not compared to data reported in previous years due to changes in methodology used for calculating this indicator. The methodology was updated for consistency between fatal and nonfatal injury reporting. The rate now includes only motor vehicle traffic incidents. Rates for prior years using these updated inclusion criteria: 2000 = 2.6; 2001 = 2.7; 2002 = 2.6; 2003 = 3.2; 2004 = 2.7; 2005 = 2.8; 2006 =2.4.

Notes - 2007
Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2008 California Death Statistical Master File [The ICD-10 codes for fatal MV traffic injuries are: V30-V79(.4-.9), V81.1, V82.1, V83-V86(.0-.3), V20-V28(.3-.9), V29(.4-.9), V12-V14 (.3-.9), V19(.4-.6), V02-V04 (.1,.9), V09.2, V80(.3-.5), V87(.0-.8), V89.2]. Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California. July 2007. Tabulations (by place of residence) were done by the MCAH Program.

Data for 2007 should be not compared to data reported in previous years due to changes in methodology used for calculating this indicator. The methodology was updated for consistency between fatal and nonfatal injury reporting. The rate now includes only motor vehicle traffic incidents. Rates for prior years using these updated inclusion criteria: 2000 = 2.6; 2001 = 2.7; 2002 = 2.6; 2003 = 3.2; 2004 = 2.7; 2005 = 2.8; 2006 =2.4.

Narrative:
Among fatal injuries, those due to motor vehicle collisions are most frequent. In 2008, the rate from unintentional injuries due to motor vehicle accidents was 1.7 per 100,000 children aged 0-14 years. As the 2007 and 2008 rate reflects a change in methodology used to calculate this indicator, data in the table cannot be directly compared to rates reported in prior years. Death rates from unintentional injuries due to motor vehicle collisions in children under age 15 fell significantly from 5.4 deaths per 100,000 in 1990 to 2.9 deaths per 100,000 in 2000. Accounting for methodological changes in the calculation of this indicator, the revised rate then oscillated between 2.3 and 3.2 per 100,000 during 2000-2007 but further decreased to 1.7 in 2008. The rate for African American children (2.8 per 100,000) is more than twice high as those for Whites (1.1 per 100,000) and for Asians (1.4 per 100,000). Rates for Hispanics decreased from 2.9 in 2007 to 1.9 per 100,000 in 2008.

In combination with other HSIs, this indicator enables California to identify trends in unintentional childhood injuries due to crashes, focus its prevention efforts and determine the success of these efforts. As resources allow, local MCAH programs address childhood injuries. The Vehicle Occupant Safety Program coordinates CPS efforts across California by creating essential CPS partnerships that link state and local policy, enforcement, and educational efforts.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	19.8	20.3	18.2	14.0	14
Numerator	1077	1118	1024	804	
Denominator	5434214	5505180	5641589	5762253	

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
A manual indicator is reported for 2009 based on 2008.

Notes - 2008
Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2008 California Death Statistical Master File [The ICD-10 codes for fatal MV traffic injuries are: V30-V79(.4-.9), V81.1, V82.1, V83-V86(.0-.3), V20-V28(.3-.9), V29(.4-.9), V12-V14 (.3-.9), V19(.4-.6), V02-V04 (.1,.9), V09.2, V80(.3-.5), V87(.0-.8), V89.2].

Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California. July 2007. Tabulations (by place of residence) were done by the MCAH Program.

Data for 2007 and 2008 should be not compared to data reported in previous years due to changes in methodology used for calculating this indicator. The methodology was updated for consistency between fatal and nonfatal injury reporting. The rate now includes only motor vehicle traffic incidents. Rates for prior years using these updated inclusion criteria: 2000 = 14.2; 2001 = 18.7; 2002 = 21.0; 2003 = 20.8; 2004 = 19.7; 2005 = 19.7; 2006 =19.8.

Notes - 2007
Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2008 California Death Statistical Master File [The ICD-10 codes for fatal MV traffic injuries are: V30-V79(.4-.9), V81.1, V82.1, V83-V86(.0-.3), V20-V28(.3-.9), V29(.4-.9), V12-V14 (.3-.9), V19(.4-.6), V02-V04 (.1,.9), V09.2, V80(.3-.5), V87(.0-.8), V89.2]. Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California. July 2007. Tabulations (by place of residence) were done by the MCAH Program.

Data for 2007 should be not compared to data reported in previous years due to changes in methodology used for calculating this indicator. The methodology was updated for consistency between fatal and nonfatal injury reporting. The rate now includes only motor vehicle traffic incidents. Rates for prior years using these updated inclusion criteria: 2000 = 14.2; 2001 = 18.7; 2002 = 21.0; 2003 = 20.8; 2004 = 19.7; 2005 = 19.7; 2006 =19.8.

Narrative:
In 2008 the death rate from unintentional injuries due to motor vehicle traffic collisions was 14.0 per 100,000 children aged 15 through 24 years. Although the recent decrease is a positive sign overall, deaths due to motor vehicle traffic injuries in this age group continue to be elevated and remain much higher than the Healthy People (HP) 2010 objective of 9.2 deaths per 100,000 for the general population. Injury is the leading cause of death among adolescents and young adults aged 15-24 years, and among fatal injuries those due to motor vehicle collisions are most frequent.
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In combination with other HSIs, this indicator enables California to identify trends in unintentional childhood injuries due to crashes, focus its prevention efforts and determine the success of these efforts. As resources allow, local MCAH programs address childhood injuries. The Vehicle

Occupant Safety Program coordinates CPS efforts across California by creating essential CPS partnerships that link state and local policy, enforcement, and educational efforts.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	239.0	210.9	198.0	194.0	194
Numerator	18954	17350	16233	15880	
Denominator	7930829	8228513	8200066	8184698	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
A manual indicator is reported for 2009 based on 2008.

Notes - 2008
Source: Numerator: State of California, Office of Statewide Health Planning and Development, Patient Discharge Data (OSHPD-PDD), January 1-December 31, 2008. Principal external cause of injury codes were used (E800-E999). Data exclude cases with iatrogenic codes (adverse effects of medical care and drugs), unknown age, newborns, persons who died in the hospital, and records erroneously listing a "place of injury" code (E849.0-E849.9) as the principal code.

Denominator: Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007. Tabulations (by place of residence) were done by the MCAH Program.

Data for 2006-2008 should be not compared to data reported in previous years due to updates in the 2000-2050 population projections released by the California Department of Finance (July 2007). Rates for prior years using these updated population estimates: 2000 = 284.9; 2001 = 273.4; 2002 = 266.2; 2003 = 257.3; 2004 = 250.7; 2005 = 229.2.

Notes - 2007
Source: Numerator: State of California, Office of Statewide Health Planning and Development, Patient Discharge Data (OSHPD-PDD), January 1-December 31, 2007. Principal external cause of injury codes were used (E800-E999). Data exclude cases with iatrogenic codes (adverse effects of medical care and drugs), unknown age, newborns, persons who died in the hospital, and records erroneously listing a "place of injury" code (E849.0-E849.9) as the principal code.
Denominator: Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007. Tabulations (by place of residence) were done by the MCAH Program.

Data for 2006-2007 should be not compared to data reported in previous years due to recent updates in the 2000-2050 population projections released by the California Department of

Finance (July 2007). Rates for prior years using these updated population estimates: 2000 = 284.9; 2001 = 273.4; 2002 = 266.2; 2003 = 257.3; 2004 = 250.7; 2005 = 229.2.

Narrative:
Hospitalization rates for all nonfatal injuries among children aged 0-14 years has decreased since 2000, when it was 284.9 per 100,000. By 2003 it had dropped to 257.3 per 100,000, and the downward trend has continued falling to 194.0 per 10,000 in 2008.

The nonfatal injury rate for 2008 is highest for African American children aged 0-14, at 279.0 per 100,000 followed by White children at 204.9 per 100,000. Rates are lower among Hispanic (182.4 per 100,000), Asian/Pacific Islander (108.3 per 100,000) and American Indian (85.3 per 100,000) children aged 0-14 years of age.

This indicator enables the State to identify trends, focus its prevention efforts and determine the success of these efforts. EPICenter California Online Injury Data web site contains static tables and dynamic web based query system for general and specific injuries e.g., motor vehicle injuries. Kids Plates Program increases the capacity of local organizations statewide to prevent childhood nonfatal injuries (e.g., traumatic brain injury, drowning, and burns) by providing grants, technical assistance and training for projects on bicycle safety, child passenger safety, poisoning, etc.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	30.9	26.5	23.0	19.6	19.6
Numerator	2449	2182	1887	1608	
Denominator	7930829	8228513	8200066	8184698	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
A manual indicator is reported for 2009 based on 2008.

Notes - 2008
Source: Numerator: State of California, Office of Statewide Health Planning and Development, Patient Discharge Data (OSHPD-PDD), January 1-December 31, 2008. Principal external cause of injury codes were used (ICD9-CM codes E810-E819). Data exclude cases of unknown age, newborns, and persons who died in the hospital.

Denominator: Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007.
Tabulations (by place of residence) were done by the MCAH Branch.

Data for 2006-2008 should be not compared to data reported in previous years due to updates in the 2000-2050 population projections released by the California Department of Finance (July 2007). Rates for prior years using these updated population estimates: 2000 = 39.6; 2001 = 35.9; 2002 = 36.4; 2003 = 35.9; 2004 = 35.4; 2005 = 29.6.

Notes - 2007
Source: Numerator: State of California, Office of Statewide Health Planning and Development, Patient Discharge Data (OSHPD-PDD), January 1-December 31, 2007. Principal external cause of injury codes were used (ICD9-CM codes E810-E819). Data exclude cases of unknown age, newborns, and persons who died in the hospital.
Denominator: Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007.
Tabulations (by place of residence) were done by the MCAH Branch.

Data for 2006-2007 should be not compared to data reported in previous years due to recent updates in the 2000-2050 population projections released by the California Department of Finance (July 2007). Rates for prior years using these updated population estimates: 2000 = 39.6; 2001 = 35.9; 2002 = 36.4; 2003 = 35.9; 2004 = 35.4; 2005 = 29.6.

Narrative:
The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger continues to decline. In 2008, the rate of nonfatal hospitalizations due to motor vehicle crashes was 19.6 per 100,000; a 50 percent decline compared to the 2000 rate of 39.6 per 100, 000.

This indicator enables the State to identify trends, focus its prevention efforts and determine the success of these efforts. California's VOSP coordinates CPS efforts across California by creating essential CPS partnerships that link state and local policy, enforcement, and educational efforts. VOSP supports CPS programs through programmatic and technical support, educational resources, data, and funding of CPS technician trainings.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	153.5	146.7	135.4	110.8	110.8
Numerator	8341	8074	7638	6385	
Denominator	5434214	5505180	5641589	5762253	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
A manual indicator is reported for 2009 based on 2008.

Notes - 2008
Source: Numerator: State of California, Office of Statewide Health Planning and Development, Patient Discharge Data (OSHPD-PDD), January 1-December 31, 2008. Principal external cause of injury codes were used (ICD9-CM codes E810-E819). Data exclude cases unknown age, newborns and persons who died in the hospital.

Denominator: Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007.
Tabulations (by place of residence) were done by the MCAH Program.

Data for 2006-2008 should be not compared to data reported in previous years due to recent updates in the 2000-2050 population projections released by the California Department of Finance (July 2007). Rates for prior years using these updated population estimates: 2000 = 147.7; 2001 = 152.0; 2002 = 162.4; 2003 = 164.2; 2004 = 164.5; 2005 = 156.0.

Notes - 2007
Source: Numerator: State of California, Office of Statewide Health Planning and Development, Patient Discharge Data (OSHPD-PDD), January 1-December 31, 2007. Principal external cause of injury codes were used (ICD9-CM codes E810-E819). Data exclude cases unknown age, newborns and persons who died in the hospital.
Denominator: Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007.
Tabulations (by place of residence) were done by the MCAH Program.

Data for 2006-2007 should be not compared to data reported in previous years due to recent updates in the 2000-2050 population projections released by the California Department of Finance (July 2007). Rates for prior years using these updated population estimates: 2000 = 147.7; 2001 = 152.0; 2002 = 162.4; 2003 = 164.2; 2004 = 164.5; 2005 = 156.0.

Narrative:
Motor vehicle traffic crashes are the leading cause of hospitalized nonfatal injuries among youth aged 15-24 in California. While hospitalization rates in this population increased during the first part of the decade; rising from 147.7 per 100,000 in 2000 to 164.5 per 100,000 in 2004; this rate has decreased markedly over the past four years. In 2008, there were 110.8 per 100,000 nonfatal injuries due to motor vehicle traffic crashes in youth aged 15 through 24 years. (Numerators are based on principal diagnoses codes in hospital discharge data.)

This indicator enables the State to identify trends, focus its prevention efforts and determine the success of these efforts. The Graduate License Program and school programs on safe driving address this measure. The State Epidemiologic Work Group gathers and publishes data on alcohol and other drug consumption and consequences, i.e., risk factors for injuries to youth. Medical Crash Outcomes Data: links crash and medical records to document how "crash" circumstances affect medical outcomes.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	22.8	22.8	23.1	23.5	23.5
Numerator	30766	31783	33303	34616	
Denominator	1348905	1395105	1438740	1470271	

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
A manual indicator is reported for 2009 based on 2008 data.

Notes - 2008
Numerator: Sexually Transmitted Diseases in California, 2008. California Department of Public Health, STD Control Branch, November 2009.

Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000–2050. Sacramento, CA, July 2007. Accessed October 2, 2008.

Notes - 2007
Numerator: California Department of Public Health, STD Branch, Chlamydia , Cases and Rates by Race/Ethnicity, Gender and Age Group, California, 2007. Available at: http://ww2.cdph.ca.gov/data/statistics/Documents/STD-Data-LHJ-StateSummary.pdf. Accessed October 2, 2008. The full report, Sexually Transmitted Disease in California, 2007, is available at http://www.cdph.ca.gov/data/statistics/Documents/STD-Data-2007-Report.pdf. Accessed 4/6/2009.
Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000–2050. Sacramento, CA, July 2007. Accessed October 2, 2008.

Narrative:
Chlamydia trachomatis (CT) infection is the most common reportable communicable disease in California. There were over 149,000 cases of CT infection in 2008, accounting for over 83% of reported STD cases statewide. The majority of cases were primarily young women. In 2008, over 70,000 cases were reported in females aged 15-24 years, accounting for 70% of female CT cases. The rate per 1,000 women aged 15 through 19 years with a reported CT case was 23.5 in 2008. The rate has increased over the past five years, up from 22.3 cases per 1,000 women aged 15-19 in 2004. Female African Americans aged 15-19 continue to have the highest CT rate at 67.1 per 1000 in 2008, up from 63.7 per 1000 in 2007. In contrast, the 2008 rates for Whites (8.3 per 1000) decreased slightly while the rate for Asian/Pacific Islanders (6.2 per 1000), and Latinas (17.0 per 1000) remained the same. It should be noted, however, that while case-based CT rates show consistent increases over time, this may be due to increased screening and use of more sensitive screening tests. As California has high screening levels for young women compared to national estimates, data from sentinel prevalence monitoring in specific health care settings are important for comparison with case-based rates.

For 15-24 year old females seen across health care settings, CT prevalence has been fairly stable since 2000. In 2008, overall female positivity in STD clinics decreased from 10.8 percent in 2007 to 9.9 percent. CT positivity in females aged 15 to 24 years in family planning sites decreased from 6.2 percent in 2007 to 5.9 percent in 2008, while this was 18.1 percent in STD clinics. Both figures exceed the HP 2010 objective of 3 percent for females age 15-24 in STD and family planning clinics. CT positivity levels in managed care settings rose slightly from previous years, which may reflect an actual increase in prevalence or changes in screening practices.

Many CT control strategies focus on young women. With effective public and private partnerships and involvement of key community stakeholders, STD Control Branch efforts, coordinated with

resources from CDPH partners, include:
1) Community and individual behavior change interventions to increase awareness and screening, particularly awareness of CT screening for adolescent girls.
2) Clinical and laboratory services to increase CT screening among sexually active women age 25 and younger in managed care, family planning, and juvenile detention settings.
3) Public/private collaboration to develop innovative strategies to reduce disparities in CT infection rates among populations of special emphasis, specifically adolescents and African Americans.
4) QI efforts including analysis of individual provider screening data accompanied by provider feedback, and chart audits of/technical assistance to low performers to enhance CT screening among women age 25 and under.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	9.1	9.7	10.1	10.2	10.2
Numerator	59668	62758	65472	66734	
Denominator	6579780	6486794	6501606	6524678	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
A manual indicator is reported for 2009 based on 2008 data.

Notes - 2008
Numerator: Sexually Transmitted Diseases in California, 2008. California Department of Public Health, STD Control Branch, November 2009.

Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000–2050. Sacramento, CA, July 2007. Accessed October 2, 2008.

Notes - 2007
Numerator: California Department of Public Health, STD Branch, Chlamydia , Cases and Rates by Race/Ethnicity, Gender and Age Group, California, 2007. Available at: http://ww2.cdph.ca.gov/data/statistics/Documents/STD-Data-LHJ-StateSummary.pdf. Accessed October 2, 2008. The full report, Sexually Transmitted Disease in California, 2007, is available at http://www.cdph.ca.gov/data/statistics/Documents/STD-Data-2007-Report.pdf. Accessed 4/6/2009.
Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000–2050. Sacramento, CA, July 2007. Accessed October 2, 2008.

Narrative:

In 2008, 10.2 per 1,000 women aged 20 through 44 years had a reported case of CT. More than 66,000 cases were reported among females aged 20-44 years, representing 33% of reported female CT cases overall.

While the chlamydia rate among women aged 20-44 is considerably lower that for women aged 15-19, this figure has similarly been rising over the past five years. Rates for women aged 20 through 44 increased from 8.6 per 1,000 in 2004, to 9.1 per 1,000 in 2005, up to 10.2 per 1,000 in 2008. However, as discussed in HSCI 5a above, the increases seen in case-based CT rates may be due to screening practices, including targeted screening of older women and the use of more sensitive screening tests. Use of case rates alone may not be adequate for evaluating impact of CT control interventions in statewide or local settings/populations. Other health status measures to consider include: CT positivity rates, the percent having been tested for CT in the past year, repeat testing rates (to reduce repeat infections), and population-based or clinic-based behavioral surveillance to assess awareness and access to CT testing.

Additionally, the combined 20-44 years age group is not particularly useful for monitoring populations at risk for CT, as case rates in women 20-24 and 25-29 are significantly higher than rates among women age 30 and older. In 2008, CT rates among women were highest for the 20-24 group at 29.1 per 100,000 women.

The STD Control Branch multifaceted strategy to reduce CT prevalence includes working in the domains of behavior change, clinical and laboratory services, surveillance, quality improvement, and leadership. In addition to efforts outlined in HSCI 5a above, the Branch has released guidelines for expedited partner therapy and field therapy for CT to address infections among partners.
Surveillance efforts aim to enhance timeliness and completeness of CT case data and prevalence monitoring test result data through electronic transmission. Leadership and partner development efforts include initiatives such as 1) working with outside partners to address inequities in CT rates associated with race/ethnicity, and 2) partnering with medical groups to provide CT screening rates to individual providers.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	551496	443657	31632	2309	60270	2512	11116	0
Children 1 through 4	2171886	1729498	113130	6533	222549	8056	92120	0
Children 5 through 9	2673199	2125381	142892	9186	247816	8273	139651	0
Children 10 through 14	2788117	2239211	174327	17126	264065	10273	83115	0
Children 15 through 19	3019105	2404137	210094	19660	295071	11591	78552	0
Children 20 through 24	2743148	2148807	190709	18650	308848	11417	64717	0
Children 0 through 24	13946951	11090691	862784	73464	1398619	52122	469271	0

Notes - 2011

Narrative:
California's child population continues to increase reaching an estimated 13,946,951 in 2008. In most counties, the overall population as well as the estimated child population increased from 1995 to 2008. By race, 11,090,691 (80%) were White; 1,398,619 (10%) were Asian; 862,784 (6.2%) were African American; 469,271 (3.4%) were multi-racial; 73,464 (0.5%) were American Indian or Alaska Native (AIAN), and 52,122 (0.5%) were Native Hawaiian or Other Pacific Islander (NHPI). Trends in the population of children and young adults help project potential needs for, health care, and public health services. The increasing racial and ethnic diversity poses challenges to health care delivery and the public health system. More than ever, MCAH is continually addressing cultural competence and cultural differences in to ensure access to services and address disparities

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	271331	2800165	0
Children 1 through 4	1076632	1095254	0
Children 5 through 9	1345824	1327375	0
Children 10 through 14	1443191	1344926	0
Children 15 through 19	1668826	1350279	0
Children 20 through 24	1637054	1106094	0
Children 0 through 24	7442858	9024093	0

Notes - 2011

Narrative:
Of the 2008 population aged 0-24 years, a total of 6,504,093 (47%) were of Hispanic ethnicity. Across the U.S., California has the largest population of Hispanic residents and the largest percentage of Hispanics of Mexican origin.

Having an understanding of California's ethnic population characteristics and trends is important for understanding the conditions and policy challenges facing California's health care delivery and public health systems. Cultural factors such as behavior and lifestyle influence health outcomes. More than ever, MCAH is continually addressing cultural competence and cultural differences in to ensure access to services and address disparities

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**

Women < 15	624	502	47	8	13	3	33	18
Women 15 through 17	17008	14110	1234	150	395	41	671	407
Women 18 through 19	34696	27984	3000	293	891	165	1471	892
Women 20 through 34	401926	306410	21911	2102	45786	1990	10987	12740
Women 35 or older	97252	68768	3946	268	18131	365	2104	3670
Women of all ages	551506	417774	30138	2821	65216	2564	15266	17727

Notes - 2011

Narrative:
The total number of live births to California women in 2008 was 551,567. The mother's race for 417,782 (76%) births was White; for 65,216 (12%) it was Asian; for 30,138 (5%) it was African American; for 15,266 (2.8%) More Than One Race was Reported; for 2,821 (0.5%) mother's race was AIAN; and for 2,564 (0.5%) it was NHPI. For 17,780 (3.2%) births, the mother's race was Other or Unknown.

By age, 17,008 births (3.1%) were to women age 15-17, 34,696 ((6.3%) to women age 18-19, 401,926 (72.9%) to women age 20-34, and 97,252 (17.6%) to women age 35 or older. The number of live births to women under age 15 years decreased from 663 in 2007 to 624 in 2008, continuing the downward trend among all other age groups.

The number of births declined in California from 2007 to 2008, the first drop in births in more than a decade. Much of the trend was concentrated among young adults -- the number of births to women over 30 only dropped slightly. Over the next 10 years, births to women under age 25 will drop, while those to older women are projected to increase. Peak fertility rates among U.S.-born White and Asian women now occur in their early 30s, rather than in their late 20s. Peak fertility rates among U.S.-born Latinas occur in their early 20s.
Births to African American women will decrease by almost 4% by 2018 while births to Asian, American Indian and White women will moderately increase by 5.8%, 6.3% and 5.9%, respectively. Births to Pacific Islander women will increase 15.7% over the next ten years. In general, Latinas have much higher birth rates than other ethnic groups, with the highest rate in the state belonging to foreign-born Latinas (3.7 children per woman). In contrast, U.S.-born Whites and Asians have fertility rates of 1.6 and 1.4 children per woman, respectively. African American women follow a unique fertility pattern with relatively high birth rates at young ages and very low rates at older ages.

In the last two decades, California has experienced an accelerating trend in delayed childbearing.[43] A growing percentage of women are giving birth in their early forties, while a much lower percentage of teenagers are becoming mothers. Despite the rise in birth rates among older women, trends in childlessness are also increasing.

In 2008, teen birth rates in California were the lowest the state has ever recorded at 35.2 per 1000 females. There are, however, racial and ethnic differences. For African American teens, birth rates dropped by nearly two-thirds (63%) and for Latinas by almost half (46%). Rates also declined for White and Asian teens, but from much lower numbers overall.

The trend in childbearing among women over age 40 is highest among Whites and Asians. However, despite the growth of fertility rates for women in their 40s, they still represent a small share of all births: 95 percent of California women have completed childbearing by age 40. Consequently, delayed childbearing may explain substantial increases in childlessness.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	110	509	5
Women 15 through 17	3468	13358	182
Women 18 through 19	10110	24166	420
Women 20 through 34	183233	212792	5901
Women 35 or older	58548	36491	2213
Women of all ages	255469	287316	8721

Notes - 2011

Narrative:
The total number of live births to California women in 2008 was 551,567. The mother's ethnicity for 287,323 (52%) of these births was Hispanic. Younger mothers were more likely to be of Hispanic ethnicity; 82% of live births to women under age 15 and 79% of births to women aged 15-17 years were to Hispanic mothers, while 38% of live births to women aged 35 and older were to Hispanic mothers. Hispanic women will have the largest numerical increase in births over the next ten years.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	2806	1998	374	12	211	16	174	21
Children 1 through 4	462	331	55	5	36	3	31	1
Children 5 through 9	265	199	27	1	23	2	11	2
Children 10 through 14	347	261	36	2	33	2	11	2
Children 15 through 19	1290	974	180	11	67	11	38	9
Children 20 through 24	2077	1587	264	19	131	13	50	13
Children 0 through 24	7247	5350	936	50	501	47	315	48

Notes - 2011

Narrative:
The number of deaths of children age 0-24 in California in 2008 was 7,247. By race, 5,350 (74%) of the deaths were White; 936 (13%) were African American; 501 (6.9%) were Asian; 315 (4.3%) were More Than One Race Reported; 50 (0.7%) were AI/NA; and 47 (0.6%) were NH/PI. For 48 (0.7%) child deaths, race was Other or Unknown.

The crude death rate from all causes for California was 620.6 deaths per 100,000 population, a risk of dying equivalent to approximately one death for every 161 persons. This rate was based on a 2006 through 2008 three-year average number of deaths equaling 234,663.7 and population count of 37,810,582 as of July 1, 2007. The age-adjusted death rate from all causes for California during the 2006 through 2008 three-year period was 666.4 deaths per 100,000 population.[17] A Healthy People 2010 National Objective for deaths due to all causes has not been established.

Mortality rates, particularly infant mortality continues to be used as an overall health indicator for a community. California's infant mortality rate has been steadily decreasing and the gap between the current rate and the Healthy People 2010 objective is closing.

Although California's infant mortality rate for African American infants is one of the lowest in the country, African American infants born in the state are still twice as likely as other racial groups to die before their first birthday. MCAH is the lead within CDPH in reducing infant mortality. MCAH developed an action plan to address the infant mortality rate disparities.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	1297	1504	5
Children 1 through 4	230	232	0
Children 5 through 9	122	143	0
Children 10 through 14	165	182	0
Children 15 through 19	662	628	0
Children 20 through 24	1188	887	2
Children 0 through 24	3664	3576	7

Notes - 2011

Narrative:
Of the 7,247 deaths of children age 1-24 years in California in 2008, 3,576 (49%) were of Hispanic ethnicity.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	11203803	8941884	672075	54814	1089771	40705	404554	0	2008
Percent in household headed by single parent	26.1	24.9	49.4	48.5	16.1	37.8	23.5	0.0	2009
Percent in TANF (Grant) families	9.2	8.1	29.0	14.5	5.5	25.5	6.7	0.0	2008
Number enrolled in Medicaid	3497465	2722232	352055	16158	224124	0	649	182247	2008
Number enrolled in SCHIP	882434	540462	16953	2515	88851	0	0	233653	2009
Number living in foster home care	64572	44800	17288	801	1672	0	0	11	2009
Number enrolled in food stamp program	1528843	1179897	193051	2271	75399	0	46665	31560	2008
Number enrolled in WIC	1972804	1700986	119069	7126	83731	8592	42384	10916	2009
Rate (per 100,000) of juvenile crime arrests	3181.0	3062.0	8950.0	2164.0	959.0	4336.0	0.0	0.0	2008
Percentage of high school drop-outs (grade 9 through 12)	3.9	3.8	6.8	5.3	1.8	4.5	0.0	5.1	2008

Notes - 2011

For the tabulation for all children 0through 19m the data source is the State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007. http://www.dof.ca.gov/html/Demograp/Data/RaceEthnic/Population-00-50/RaceData_2000-2050.php.

For the tabulation on the percent in household headed by a single parent, the data source is the U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, March 2009. CPS Table Creator for 2009. URL: http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

The Current Population Survey (CPS) household head information refers to the year the survey is taken, not a reference year prior to the survey. CPS data for all persons aged 0-19 years, 2009, by total race and total ethnicity differs by one as shown in the table. This discrepancy appears to be already present in the source document.

Numerator is derived by adding (1) Universe, Persons in Male-Headed Primary Families, No Spouse Present , California, Ages 0-19 and (2) Universe, Persons in Female-Headed Primary Families, No Spouse Present, California, Ages 0-19,

Denominator is the Universe, Persons- All Children, California, Ages 0-19.

For the tabulation on the percent in TANF, the numerator is the number of children ages 0 to 18 in CalWORKs assistance units during FFY 2008. The CalWORKs database groups children from 0-18 years and not as 0-19 years. The White category includes non-Hispanic White, Hispanic White and Hispanic children of unknown race. Source for the Numerator; California Department of Social Services, Federal Data Reporting and Analysis Bureau. Ad hoc SAS analysis completed 12/09/2009 (unpublished)

Denominator: Number of children ages 0 to 18 in CY 2008. State of California, Department of Finance. Race/Ethnic Population with Age and Sex Detail, 2000–2050. Sacramento, CA, July 2007.

For the tabulation on the number enrolled in Medicaid, the Medicaid data included all infants and children 0-19 years enrolled in MediCal for the October 2008 month of eligibility. The data source is the RASS CINXMOE SAS Dataset created from the MEDS Eligible file with a 12 month reporting lag. The data source is the California Department of Health Care Services, Medical Care Statistics Section.

The Asian race category included Native Hawaiian and other Pacific Islanders. More Than One Race Reported category included only Amerasian ethnicity code with no other codes to identify persons of more than one race. White category includes persons identified as White or Hispanic.

For the tabulation of the number enrolled in SCHIP, the count for Asian includes Native Hawaiian and Other Pacific Islander. The count for White includes Hispanic. The HFP Monthly Enrollment Report does not include a More Than One Race Reported category. The counts for total other (202,897) and unknown (30,756) are combined to reflect the TVIS reporting category of other and unknown. The table used to collect this information on enrollments changes month by month.

The data source is the Managed Risk Medical Insurance Board, HFP Monthly Enrollment Reports, Current Enrolled for December 2008. Accessed January 12, 2009, at http://www.mrmib.ca.gov/MRMIB/HFP/Dec_07/HFPRpt5A.pdf.

For the tabulation on the number enrolled in the food stamp program, data represent the number of children in food stamp households during FFY 2008, in both public assistance and non-assistance households.
The count for Asian includes Native Hawaiian and Other Pacific Islander. The count for White includes Hispanic. Mixed Race was added as a new race category for FFY 2008.

Data was requested from the California Department of Social Services, Federal Data Reporting and Analysis Bureau, completed on completed on 10/19/2010.

For the tabulation on the number enrolled in WIC, the data source is the California Department of Public Health; Women, Infants and Children Program; Research and Evaluation Section. Unpublished data, October 2009. Data is for the period from October 2008 to September 2009.

For the tabulation on the rate of juvenile crime arrests, the numerator data include felony and misdemeanor offenses among juveniles age 19 and younger. Data is not available for the More than One Raced Reported category. Numerator data was requested from the State of California, Department of Justice, Bureau of Criminal Information and Analysis, Criminal Justice Statistics Center.

The denominator is from the State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail 2000-2050. Sacramento, California, July 2007.

For the tabulation on the percentage of high school drop-outs, rates are 1-year rates based on (the number of grade 9-12 dropouts / the number of grades 9-12 enrollments) * 100. Other and Unknown includes those identified as multiple race or no response. The numerator data source is the California Department of Education, Educational Demographics Unit. Number of Dropouts in California Public Schools, Grades 9-12 by Grade Level and Ethnicity Group, 2007- 2008. Accessed 11/3/2009 at :
http://dq.cde.ca.gov/dataquest/DropoutReporting/GradeEth.aspx?cDistrictName=State&cCounty Code=00&cDistrictCode=0000000&cSchoolCode=0000000&Level=State&TheReport=GradeEth& ProgramName=All&cYear=2006-07&cAggSum=StTotGrade&cGender=B.

For the tabulation on the number living in foster home care, the January 2009 data presented is for a point in time (accessed on 05/24, 2010) caseload for children in child welfare supervised foster care ages 0-20 years and not 0-19 years. The count for Whites includes Hispanics. The counts for Asian includes Pacific Islanders. he source document does not include a More Than One Race category.

The data source is:
Needell, B., Webster, D., Armijo, M., Lee, S., Dawson, W., Magruder, J., Exel, M., Cuccaro-Alamin, S., Williams, D., Zimmerman, K., Simon, V., Hamilton, D., Putnam-Hornstein, E., Frerer, K., Lou, C., Peng, C. & Moore, M. (2010). Child Welfare Services Reports for California. Available at: http://cssr.berkeley.edu/ucb%5Fchildwelfare/PIT.aspx . Last accessed on May 24, 2010..

Narrative:
The 2008 population of California age 0-19 was 11,203,803. By race, 80% were White; 12% Asian; 5.9% African American; 3.6% Multiracial; 0.5% AI/AN); and 0.4% NH/PI.

Of those ages 0-19, 26.1 percent lived in a household headed by a single parent in 2009. The proportion living in households headed by a single parent has been consistently highest for African American children (49.4% in 2008); figures are also high for NHPI (37.8%) and AI/AN (48.5.%) children.

There were 9.2 percent of children 0-19 years of age receiving Temporary Assistance for Needy Families (TANF) in 2008. By race, 31.6% of African American, and 23.2% of NHPI children got TANF, compared to
8.2% of White, 5.9% of AIAN; 4.9% of Asian, and 1.4% of multiracial children.

The number of children enrolled in Medi-Cal (Medicaid) in 2008 was 3,497,465. This was up 106,000 from the previous year.

In 2009, 882,434 children were enrolled in Healthy Families (SCHIP), slightly lower than the 895,440 enrolled in 2008. The 2009 enrollment includes 540,462 White children (61.2%; including Hispanic), 88,951 (10.1%) Asian; 16,953 (1.9%) African American; and 2,515 (0.3%) AI/AN. Race was Other/Unknown for 233,653 (26%) children enrolled in Healthy Families in 2009.

The foster care caseload was 64,752 at the end of 2009. This figure has been steadily decreasing since 2003, when it was 89,913.

In 2008, 1,528,843 children were enrolled in the Food Stamp Program, including: 1,179,897 (77.2%) White, (955,061 Hispanic, 573,782 non-Hispanic); 46,665 (3.0%) Multiracial; 193,051 (12.6%) African American; 75,399 (4.9%) Asian; 2,271 (0.1%) AIAN; and 31,560 (2.1%) Other/Unknown children.

Of those aged 0-19 years, 1,972,804 were enrolled in WIC in 2009. This includes 1,700,986 (86.2%) White (including Hispanic); 119,069 (6.0%) African American; 83,731 (4.2%) Asian; 42,384 (2.1%) Multiracial; 7,126 (0.4%) AIAN; 8,592 (0.4%) NHPI; and 10,916 (0.6%) Other/Unknown.

There were 3,181 arrests per 100,000 for juvenile felony and misdemeanor offenses among those under 19 years in 2008. This was a decrease over 2007, and although the rate has fluctuated, 2007 was the highest observed over the past five years. Arrest rates continue to be highest for African American (8,950 per 100,000 children) and NHPI (4,336 per 100,000) juveniles.

In the 2008-09 school year, high school dropouts (grades 9-12) decreased to 3.9 percent. This was a reversal from the past 4 years. By race, 6.8 percent of African-American, 6.0 percent of AIAN, 5.3 percent of NHPI, 3.8 percent of White, and 1.8 percent of Asian students dropped out. With the exception of Whites and Asians, all rates decreased.

Enrollment trends in various juvenile justice, health and social service programs help in planning for future service needs. California's MCAH does not fund these programs although Title V funding is used to support the maternal and child health needs of populations that utilize these programs.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	5805804	5397999	0	2008
Percent in household headed by single parent	24.5	27.7	0.0	2009
Percent in TANF (Grant) families	7.8	10.6	0.0	2008
Number enrolled in Medicaid	1167529	2207986	121950	2008
Number enrolled in SCHIP	396257	455421	30756	2009
Number living in foster home care	35619	28942	11	2009
Number enrolled in food stamp program	573782	955061	0	2008
Number enrolled in WIC	439417	1533387	0	2009
Rate (per 100,000) of juvenile crime arrests	2940.0	3274.0	0.0	2008
Percentage of high school drop-outs (grade 9 through 12)	3.1	4.7	5.1	2008

Notes - 2011
For the tabulation for all children 0through 19m the data source is the State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007.
http://www.dof.ca.gov/html/Demograp/Data/RaceEthnic/Population-00-50/RaceData_2000-2050.php.

For the tabulation on the percent in household headed by a single parent, the data source is the U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, March 2009. CPS Table Creator for 2009. URL: http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

The Current Population Survey (CPS) household head information refers to the year the survey is taken, not a reference year prior to the survey. CPS data for all persons aged 0-19 years, 2009, by total race and total ethnicity differs by one as shown in the table. This discrepancy appears to be already present in the source document.

Numerator is derived by adding (1) Universe, Persons in Male-Headed Primary Families, No Spouse Present , California, Ages 0-19 and (2) Universe, Persons in Female-Headed Primary Families, No Spouse Present, California, Ages 0-19,

Denominator is the Universe, Persons- All Children, California, Ages 0-19.

For the tabulation on the percent in TANF, the numerator is the number of children ages 0 to 18 in CalWORKs assistance units during FFY 2008. The CalWORKs database groups children from 0-18 years and not as 0-19 years. The White category includes non-Hispanic White, Hispanic White and Hispanic children of unknown race. Source for the Numerator; California Department of Social Services, Federal Data Reporting and Analysis Bureau. Ad hoc SAS analysis completed 12/09/2009 (unpublished)

Denominator: Number of children ages 0 to 18 in CY 2008. State of California, Department of Finance. Race/Ethnic Population with Age and Sex Detail, 2000–2050. Sacramento, CA, July 2007.

For the tabulation on the number enrolled in Medicaid, the Medicaid data included all infants and children 0-19 years enrolled in MediCal for the October 2008 month of eligibility. The data source is the RASS CINXMOE SAS Dataset created from the MEDS Eligible file with a 12 month reporting lag. The data source is the California Department of Health Care Services, Medical Care Statistics Section.

Total Non Hispanic category includes persons grouped in the White, African American, American Indian, Asian, and More Than One Race categories, as well as those categorized as Other within the Other and Unknown category. Ethnicity Not Reported category includes persons grouped in the Unknown category, with no response or no valid data.

For the tabulation of the number enrolled in SCHIP, the total Non Hispanic category includes persons grouped in the White, African American, American Indian, Asian, and More Than One Race categories, as well as those categorized as Other within the Other and Unknown category. The table used to collect this information on enrollments changes month by month.

The data source is the Managed Risk Medical Insurance Board, HFP Monthly Enrollment Reports, Current Enrolled for December 2008. Accessed January 12, 2009, at http://www.mrmib.ca.gov/MRMIB/HFP/Dec_07/HFPRpt5A.pdf.

For the tabulation on the number enrolled in the food stamp program, data represent the number of children in food stamp households during FFY 2008, in both public assistance and non-assistance households.

The count of Total Not Hispanic or Latino includes White Not of Hispanic Origin, Black Not of Hispanic Origin, American Indian/Alaska Native, Asian/Pacific Islander, More Than One Race Reported, and Unknown. Data was requested from the California Department of Social Services, Federal Data Reporting and Analysis Bureau, completed on completed on 10/19/2010.

For the tabulation on the number enrolled in WIC, the total Not Hispanic or Latino includes White, Black/African American, American Indian/Native Alaskan, Asian, Native Hawaiian/Other Pacific Islander, More Than One Race Reported, and Other and Unknown.

Source: California Department of Public Health; Women, Infants and Children Program; Research and Evaluation Section. Unpublished data, October 2009. Data is for the period from October 2008 to September 2009.

among juveniles age 19 and younger. Data is not available for the More than One Raced Reported category. Total Not Hispanic or Latino includes White, Black/African American, Asian, Native Hawaiian/Other Pacific Islander, and Other.Numerator data was requested from the State of California, Department of Justice, Bureau of Criminal Information and Analysis, Criminal Justice Statistics Center.

The denominator is from the State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail 2000-2050. Sacramento, California, July 2007.

For the tabulation on the percentage of high school drop-outs, the total count of Not Hispanic or Latino includes White, Black/African American, American Indian/Native American, Asian, and Native Hawaiian/Other Pacific Islander. Total count of Ethnicity Not Reported includes those identified as multiple race or no response.

Rates are 1-year rates based on (the number of grade 9-12 dropouts / the number of grades 9-12 enrollments) * 100. Other and Unknown includes those identified as multiple race or no response. The numerator data source is the California Department of Education, Educational Demographics Unit. Number of Dropouts in California Public Schools, Grades 9-12 by Grade Level and Ethnicity Group, 2007- 2008. Accessed 11/3/2009 at : http://dq.cde.ca.gov/dataquest/DropoutReporting/GradeEth.aspx?cDistrictName=State&cCountyCode=00&cDistrictCode=0000000&cSchoolCode=0000000&Level=State&TheReport=GradeEth&ProgramName=All&cYear=2006-07&cAggSum=StTotGrade&cGender=B.

For the tabulation on the number living in foster home care, the January 2009 data presented is for a point in time (accessed on 05/24, 2010) caseload for children in child welfare supervised foster care ages 0-20 years and not 0-19 years. The count for Whites includes Hispanics. The counts for Asian includes Pacific Islanders. he source document does not include a More Than One Race category.

The data source is:
Needell, B., Webster, D., Armijo, M., Lee, S., Dawson, W., Magruder, J., Exel, M., Cuccaro-Alamin, S., Williams, D., Zimmerman, K., Simon, V., Hamilton, D., Putnam-Hornstein, E., Frerer, K., Lou, C., Peng, C. & Moore, M. (2010). Child Welfare Services Reports for California. Available at: http://cssr.berkeley.edu/ucb%5Fchildwelfare/PIT.aspx . Last accessed on May 24, 2010..

Narrative:
Many of the various state programs listed above have experienced or will experience substantial cuts in service capacity due to California's ongoing budget deficit. For example, the California Work Opportunity and Responsibility to Kids (CalWORKs) Program which is the equivalent of TANF in California provides cash assistance to low-income families with children, while helping parents find jobs and overcome barriers to employment. The 2010-11 May Revision Budget proposes to: reduce CalWORKs payments by 15.7 percent effective July 1, 2010. This proposal would cut the maximum monthly payment for a family of three in high-cost counties from $694 to $585, thereby reducing cash assistance for more than 1.4 million children and parents and causing an estimated 20,500 recipients who receive small payments to lose the entire amount. CalWORKs payments have not kept pace with inflation and their purchasing power would decline further under this proposal, which would cut cash assistance by $649.4 million between June

2010 and June 2011. The 2010-11 budget proposal will also eliminate CalWORKs eligibility for 23,750 legal immigrants who have resided in the US for less than five years for savings of $57.6 million in 2010-11. An alternative proposal is to eliminate the CalWORKs Program in its entirety. This proposal would terminate cash assistance and a range of services for more than 1.4 million low-income children and parents by October 1, 2010. Eliminating CalWORKs would cause California to lose three-quarters ($2.8 billion) of the state's federal Temporary Assistance for Needy Families (TANF) block grant in 2010-11, and to lose the state's entire annual $3.7 billion TANF block grant every year thereafter. In addition, an estimated $1.8 billion in state and county CalWORKs funds would not be available to help low-income families with children in 2010-11. Moreover, California could lose more than $500 million in additional federal funds to help offset state expenditures for CalWORKs in 2010-11 if Congress extends a key provision of the American Recovery and Reinvestment Act of 2009[44] .

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	10946116
Living in urban areas	10946116
Living in rural areas	257687
Living in frontier areas	0
Total - all children 0 through 19	11203803

Notes - 2011

The data source is the Percent of the State population living in urban and rural areas from the United States Department of Agriculture, Economic Research Service, Population, Income, Education, and Employment State Fact Sheets: California. Available at: http://www.ers.usda.gov/StateFacts/CA.htm. Last accessed on November 4, 2009.

Urban and rural (metro and nonmetro) definitions are based on the Office of Management and Budget June 2003 classification. Estimated number of children living in urban (metropolitan) areas was calculated as total population 0-19 minus the estimated number of children living in rural (non-metropolitian) counties. Estimated number of children living in rural counties was calculated by multiplying the estimated number of children in the state by the percent of overall state population living in rural counties.

Denominator Source: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007.

The data source is the Percent of the State population living in urban and rural areas from the United States Department of Agriculture, Economic Research Service, Population, Income, Education, and Employment State Fact Sheets: California. Available at: http://www.ers.usda.gov/StateFacts/CA.htm. Last accessed on November 4, 2009.

Urban and rural (metro and nonmetro) definitions are based on the Office of Management and Budget June 2003 classification. Estimated number of children living in urban (metropolitan) areas was calculated as total population 0-19 minus the estimated number of children living in rural (non-metropolitian) counties. Estimated number of children living in rural counties was calculated by multiplying the estimated number of children in the state by the percent of overall state population living in rural counties.

Denominator Source: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007.

The data source is the Percent of the State population living in urban and rural areas from the United States Department of Agriculture, Economic Research Service, Population, Income, Education, and Employment State Fact Sheets: California. Available at: http://www.ers.usda.gov/StateFacts/CA.htm. Last accessed on November 4, 2009.

Urban and rural (metro and nonmetro) definitions are based on the Office of Management and Budget June 2003 classification. Estimated number of children living in urban (metropolitan) areas was calculated as total population 0-19 minus the estimated number of children living in rural (non-metropolitian) counties. Estimated number of children living in rural counties was calculated by multiplying the estimated number of children in the state by the percent of overall state population living in rural counties.

Denominator Source: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007.

The data source is the Percent of the State population living in urban and rural areas from the United States Department of Agriculture, Economic Research Service, Population, Income, Education, and Employment State Fact Sheets: California. Available at: http://www.ers.usda.gov/StateFacts/CA.htm. Last accessed on November 4, 2009.

The California State Fact Sheet from the USDA Economic Research Service did not use the term "frontier" as one of its variables or an area having fewer than six people per square mile.

Narrative:
Public health needs of rural and urban populations vary. Rural-urban health disparities exist with respect to shortages of some types of primary care physicians (obstetricians and pediatricians), shortages of specialized mental health providers and oral health providers, prevalence of tobacco use and drinking-and-driving, and delays in screening and diagnosis of cancer. In addition, particular geographic, demographic, and cultural conditions in rural areas present obstacles to both rural residents seeking services and providers who would deliver them.(45)

Disparities in chronic disease prevalence and related health behaviors, issues of diversity and shifting population demographics, and access and coverage for the underinsured & uninsured all become more complicated in rural areas. MCAH LHJs in rural areas, in addressing these issues, face challenges regarding workforce recruitment, retention and training, epidemiologic investigation, information technology, and telecommunications. Many social determinants of health unique to rural areas impact health status. Some examples include lower wages, disproportionately high housing costs (relative to wages), psychological impacts associated with increased isolation, fewer jobs, high numbers of underinsured or uninsured, increased risk of poverty, and lack of educational opportunities. Taken together, these factors contribute to increased inequities in the health status of rural residents.

Similarly, the built environment in urban areas creates opportunities and challenges. Higher concentrations of people make it easier to offer basic infrastructure and public health services. However, urbanization tends to create health hazards making it more environmentally as well as socially unsustainable. Health hazards resulting from urbanization are mainly connected to air pollution, as well as crime, traffic and lifestyle. A health hazard common in, but not exclusive to, the cities in California is connected to lifestyle and consumption patterns, including dietary changes and obesity.

There is interest and recognition within MCAH to address health inequities in the rural and urban population. To address health disparities, MCAH will take into account differences in rural and urban settings, with strategies that focus on environmental changes involving all sectors, through

local programs, and policies to create social norm changes.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	36246576.0
Percent Below: 50% of poverty	6.1
100% of poverty	14.7
200% of poverty	34.3

Notes - 2011

Narrative:
There are numerous possible approaches to improving the health of poor populations. The most essential task that CDPH is striving for is to ensure the satisfaction of basic human needs such as clean air, safe drinking water, and adequate nutrition. Other approaches adopted by the CDPH programs include reducing barriers to the adoption of healthier modes of living and improving access to appropriate and effective health and social services.

A growing body of research confirms the existence of a powerful connection between socioeconomic status and health. MCAH understands poverty and its effects on health and together with its stakeholders, endeavors to influence local and state policymakers to reduce the burden of ill health that is a consequence of poverty.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	10352918.0
Percent Below: 50% of poverty	8.1
100% of poverty	20.5
200% of poverty	43.3

Notes - 2011

Narrative:
Children in poverty frequently live in stressful environments, without the necessities most children have, including adequate nutrition to enable physical and cognitive development. Children from low-income families are more likely to go hungry; reside in overcrowded or unstable housing; live in unsafe neighborhoods; and receive a poorer education. They also tend to have less access to health care, child care, and other community resources, such as quality after-school programs, sports, and extracurricular opportunities.

From a life course perspective, poverty is a barrier to opportunity, with poor children more likely to have diminished access to health care translating to poorer health outcomes or do poorly in school translating into lower lifetime earnings. Although family violence, youth substance abuse,

and juvenile crime are found across the socioeconomic spectrum, child poverty is correlated with these risk factors as well.

MCAH understands poverty and its effects on health and together with its stakeholders, endeavors to influence local and state policymakers to reduce the burden of ill health that is a consequence of poverty.

F. Other Program Activities

>MCAH Hotline, MCAH Web Hits and the National Text4baby

Both the State and LHJs have telephone hotlines that provide information regarding maternal, child and adolescent health services and programs. There are several statewide toll free telephone hotlines run by the State of California, including one for MCAH: 1-866-241-0395. The combined number of telephone calls to the local MCAH toll-free lines was 49,748 in FY 2008-09, up from 42,239 in FY 2007-08.

The MCAH web site received 57,323 hits from June 1, 2008 through July 30, 2009. Local MCAH web sites have also been accessed by community members. For example, Contra Costa County reported receiving 84,074 hits to their MCAH web site.

Text4baby is a free mobile information service designed to promote maternal and child health. An educational program of the National Healthy Mothers, Healthy Babies Coalition, Text4baby provides pregnant women and new moms with information they need to take care of their health and give their babies the best possible start in life. Of the 42,518 who enrolled in text4baby nationwide as of May 2010, 9.5% (n= 4024) of women were from California.

>Emergency Preparedness

CDPH launched a program to help Californians find local H1N1 and seasonal influenza immunization information using cell phone texting inquiries, Facebook applications, Twitter and Web widgets. CDPH is promoting the campaign through outdoor advertising, public service announcements and social media. CDPH also launched a new television campaign, entitled "Hands", that lays out the simple facts about H1N1 and encourages vaccination.

MCAH continues to be active in providing updated information about H1N1, perinatal transport and breastfeeding in emergency situations on their website and to LHJs. The information offered is appropriate for pregnant women, parents, clinicians and health officials. Several local MCAH programs participate in collaboratives and have developed activities regarding emergency preparedness for the MCAH population

>Home Visiting Programs

Ten counties in California utilize Nurse Family Partnership (the David Olds home visiting model) to follow high-risk, first-time pregnant women, their children and families. The Olds model is a home visitation model that utilizes public health nurses; other counties utilize a home visitation format with staff ranging from community health workers to registered nurses.

A few counties are applying for federal grants to run the Nurse Family Partnership. Also, a few local Public Health Departments are developing or currently implementing their own home visiting programs to provide assessment of mother and infants, health education, and information and referral for needed services.

>Human Stem Cell Research (HSCR) and Women's Reproductive Health

MCAH created the HSCR Program in 2005 to fulfill legislative mandates through the development of statewide research guidelines, protections for women donating oocytes for research, requirements for HSCR review and approval, and HSCR reporting requirements.

MCAH convened the HSCR Advisory Committee in 2006. In 2007, CDPH approved the statewide guidelines for HSCR submitted by the Advisory Committee. These guidelines were revised in 2008 and 2009 to reflect advancements in the HSCR field.

The HSCR Program developed reporting forms for research involving human embryonic stem cells and oocyte retrieval in spring 2008. In the first year of data collection, 15 review committees reported on 244 HSCR projects. In the second year of reporting, 18 review committees reported on 303 HSCR projects.

>Prenatal Screening Services, Umbilical Cord Blood Banking, and Pregnancy Blood Banking
The California Birth Defects Monitoring Program (CBDMP) was established in 1982 to conduct research and surveillance of birth defects and maintain a birth defect registry. CBDMP was moved to CDPH in July 2007. Legislation passed in September 2006 expanded the program's capacity to discover causes, develop prevention strategies, and increase surveillance of birth defects and genetic diseases throughout the state. CBDMP collaborates with the Genetic Disease Screening Program (GDSP) to maintain the Pregnancy Blood Bank, which stores blood samples from GDSP's Prenatal Screening Program.

>Oral Health Promotion
MCAH recognizes the importance of oral health as being integral to overall health and is responding with a variety of strategies to increase this awareness among its targeted populations. MCAH is contracting with UCSF for a dental hygienist to serve as the MCAH Oral Health Policy Consultant to provide technical assistance at both the state and local levels. Guidelines within MCAH programs have been revised to include oral health recommendations for pregnant and postpartum women and their young children. MCAH collaborates with organizations concerned with promoting oral health throughout the state, including formulating recommendations for the newly completed statewide perinatal oral health guidelines.

State budget cuts to the Children's Dental Disease Prevention Program (CCDDP) and Medi-Cal adult dental services will be very challenging to MCAH LHJs which provide education and referrals to their clients. MCAH has 18 LHJs that have selected oral health as a priority objective. Eleven of these programs have a minimum of one part-time oral health coordinator/consultant on staff. Another 25 LHJs collaborate on community dental health advisory boards. The boards develop and implement local dental screening and prevention programs and work to increase access by encouraging more dentists to become Denti-Cal providers.

G. Technical Assistance

MCAH requests training and resource materials in the area of capacity assessment, including: 1) Clinical capacity assessment (availability of and access to clinics, maternity beds, neonatal intensive care units, etc); 2) Clinical workforce assessment at state and county levels (physicians, obstetrician/gynecologists, pediatricians, dentists, nurses, etc); 3) Public health capacity assessment (epidemiologists, program evaluators, etc); 4) Integration of needs assessment, capacity assessment, and implementation planning, and; 5) MCAH public health workforce assessment.

MCAH requests guidance in conducting the Home Visitation Program Needs Assessment as mandated by the Maternal, Infant, and Early Childhood Home Visiting Program in the Patient Protection and Affordable Care Act. Specifically, MCAH requests assistance in identifying the

criteria by which MCAH can measure the effectiveness of evidence-based early childhood home visiting models that qualify under the new legislation, guidelines for reporting to fulfill the needs assessment requirements and developing quantifiable measures for setting benchmarks.

MCAH requests training and resource materials in the area of capacity assessment, specifically on : 1) developing process indicators related to direct healthcare services; (2) community level capacity assessment; (3) linking needs analysis with capacity assessment to identify priorities and resource allocation and (4) "train the trainer" on conducting state and community-level capacity assessment 5) internal organizational capacity assessment 6) scope and breadth in assessing systems capacity beyond MCAH services.

MCAH requests assistance in reviving an annual (or biennial) MCAH California Conference. The conferences would be a collaborative effort undertaken by the MCAH, MCAH Action (the statewide organization of local MCAH Directors), and the UCB School of Public Health. Such conferences were held annually in California prior to discontinuation in 2002 due to budget constraints. The conferences were well attended, with approximately 700 participants each.

Conference locations alternated between northern and southern California. The conference provided opportunities for participants --from the state, local jurisdictions, academia, and other interested groups --to network and strategize on issues affecting the health of women, children and families in California. Each year the conference had a theme. MCAH encouraged interested parties to submit general or scientific abstracts on current and emerging MCAH issues pertinent to the theme. Programs that addressed the conference theme were recognized.

MCAH has an excellent staff of researchers and analysts for epidemiological analyses and evaluation of Title V programs. However, MCAH requests training for recent hires and junior research staff on several aspects of the methodology of epidemiological analyses of maternal, child, and adolescent health and program evaluation. CMS would also benefit from receiving training on these issues, including epidemiological methods, analyses of the cost-effectiveness or budget neutrality of programs, and the analysis of trend data. While it would be desirable to obtain this training directly through seminars and workshops offered at CDC, HRSA, and other Federal agencies, policies designed to address budget constraints in California prohibit out-of-state travel.

A workshop on epidemiology (e.g., risk ratios, sensitivity, specificity, validation, and bias) and appropriate statistical analyses commonly used in maternal, child, and adolescent health would be valuable to both the MCAH and CMS. Applied examples, including examples of analyses commonly used by comparable state and federal entities, would demonstrate concepts and inform possible areas for enhanced analysis and program development. Many MCAH programs are local; data collected at the state level may be useful for smaller areas, so an overview of small-area and geographic analysis would also enhance current and suggest future analyses.

Technical assistance on how to conduct cost-effectiveness, cost-benefit, and cost avoidance analyses for Title V programs would also be very beneficial for staff. During the current era of budget shortfalls in California, there has been greater scrutiny by decision-makers as to the cost-effectiveness and fiscal neutrality of programs run by the MCAH and CMS.

Technical assistance on the steps involved in analyses, parameters to consider, accepted methodologies, and effective presentation of results would supplement staff's ability to provide this critical information to program managers and administration officials.

Hands-on training on smoothing techniques to deal with geographic areas (e.g., census tracts) for which there are too few observations to generate statistically stable counts or rates; recommended statistical tests for use with geospatial data, including for smoothed data.

Maternal Morbidity and Mortality The CDC reports that more than 40 percent of women

experience some type of complication during childbirth; many of these complications are preventable. Maternal morbidity is a serious public health problem that can impact maternal, fetal, and infant health and can lead to maternal death. MCAH is working to monitor maternal morbidity. MCAH is developing a MQI project and has contracted with an academic research group to assess variation in maternal outcomes and an evidence-based quality improvement collaborative to analyze the data. MCAH requests assistance in the development of systems for identifying, reviewing, and analyzing maternal morbidity that will serve as a framework for improved maternal standards of care.

MCAH requests assistance in how to obtain youth input into decision-making for the Branch and its adolescent-related programs. Currently, the Branch does not have sufficient manpower to carry out this activity, but would like to include more youth input into our decision-making process.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	42942093	45687729	43328678		43315317	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	707354582	1231758556	1245840182		1290479684	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	0	0	0		0	
6. Program Income *(Line6, Form 2)*	622660555	1192760318	1158080012		1236656992	
7. Subtotal	1372957230	2470206603	2447248872		2570451993	
8. Other Federal Funds *(Line10, Form 2)*	269644	300918	94644		2221953	
9. Total *(Line11, Form 2)*	1373226874	2470507521	2447343516		2572673946	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	46823472	55692221	45696427		28042839	
b. Infants < 1 year old	39092553	40914562	38258951		35440694	
c. Children 1 to 22 years old	148153109	142368956	145201447		120612014	
d. Children with Special Healthcare Needs	1134481953	2227844135	2213690656		2383717501	
e. Others	0	0	0		0	
f. Administration	4406143	3386729	4401391		2638945	
g. SUBTOTAL	1372957230	2470206603	2447248872		2570451993	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	94644		94644		93713	
c. CISS	0		0		132000	
d. Abstinence Education	0		0		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	0		0		0	
h. AIDS	0		0		0	
i. CDC	175000		0		175000	
j. Education	0		0		0	
k. Other						
Others	0		0		1821240	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	1019093453	2091748671	2079144312		2247648806	
II. Enabling Services	251534756	248006059	268379701		260227739	
III. Population-Based Services	62393852	76573608	62092633		36067685	
IV. Infrastructure Building Services	39935169	53878265	37632226		26507763	

V. Federal-State Title V Block Grant Partnership Total	1372957230	2470206603	2447248872		2570451993	

A. Expenditures

The budget and expenditures for FFY 2011 are presented in Forms 2, 3, 4, and 5.

B. Budget

Since the enactment of the Omnibus Budget Reconciliation Act 89, California has maintained the availability of Title V funds under both the maintenance of effort and the match requirements. The California Title V agency will continue to do so in the coming year.

The proposed allocation of Title V funds for California for FFY 2011 is $43,315,317. Preventive and primary services for pregnant women, mothers, and infants are designated to receive $12,800,106 (29.55 % of the total), preventive and primary services for children to receive $14,272,848 (32.95 %) and CSHCN to receive $13,603,489 (31.41%).

> State Match/Overmatch

California expects to receive $43,315,317 in Federal Title V Block Grant funds for FFY 2011. The required match is $32,486,488. California's FFY 2011 expenditure plan for MCAH programs includes $1,290,479,684 in state funds. The dramatic increase in California's expenditure plan for FFY 2011 for the provision and coordination of services to the Title V MCAH population is due to the reporting of CSHCN data on actual expenditures. Previously the Electronic Data Systems (EDS) MR 922 report was used to provide the data for these numbers. However, a change to the EDS system for this report changed something in the data compilation and the numbers were not correct as they were grossly understating the expenditure data. Therefore, numbers from previous years' data submission to this year's data submission show a marked increase for the expenditures as the number is projected upon the actual expenditure data from FY 09/10 instead of the MR 922 report. Reporting of expenditure data has been updated and no longer uses the report it used in prior years.

>Administrative Costs Limits

In FFY 2011 no more than 10 percent of the Federal Title V MCH Block Grant funds will be used for administrative costs related to each program component. During FFY 2011, California will expend only 6.09 percent of Title V funds on administrative costs.

>Definition of Administrative Costs

In this Application, administrative costs are defined as the portion of the Title V dollars used to support staff in the MCAH Division Operations Sections. Funds supporting State program and data staff (but not administrative staff) in MCAH and CMS are considered to be program rather than administrative costs.

Administrative costs include staff and operating costs associated with the administrative support of MCAH. These support functions include, but are not limited to, contract management, accounting, budgeting, personnel, audits and appeals, maintenance of central contract files, and clerical support for these functions.

>"30-30" Minimum Funding Requirement

At least 30 percent of the MCH Title V Block Grant funds will be used for children's preventive and primary care services delivered within a system which promotes family-centered, community-based, coordinated care. At least 30 percent of the Title V Block Grant funds will be used to provide services to CSHCN delivered in a manner which promotes family-centered, community

based, coordinated care.

In some cases, the CDPH uses estimates to assess expenditures for both individuals served and the types of services provided. These estimates are based on the target population and program activities authorized in statute, excluding the State budget, and specified in the scope of work for each contractor. Requiring contractors to bill according to actual amounts spent on each type of individual served and by service provided is not possible within current administrative and fiscal policies. Changing State contractual policies would result in undue financial and administrative hardship to local governments and non-profit community-based organizations. This added burden without increased funding would result in many of them not being able to continue to provide needed services to women and children in the state.

>Maintenance of State Effort
CDPH has an ongoing commitment to provide maternal and child health services to women and children within the State of California. This commitment includes continued support to local health jurisdictions, local programs, clinics and Medi-Cal providers for maternal and child health services.

It is the State's intent to ensure that State General Fund contributions to these local programs, which are also funded in part by the Federal Title V Block Grant, be administered by MCAH and CMS.

The State's General Fund contribution for FFY 2011 is $1,290,479,684 which is $1,203,320,934 greater than the State's General Fund contribution of $87,158,750 in base year FFY 1989.

>BUDGET IMPACT
The combined effect of the state's budget deficit and loss of revenues due to the economic downturn resulted in a budget gap of $26.3 billion for Fiscal Year 2009-10. All California State General Funds (SGF) for MCAH were eliminated effective July 1, 2009, reducing the state and local MCAH Program budget by $20.3 million in SGF and $12 million in related matching Federal Title XIX funds.

The loss of SGF to MCAH Programs, BIH, AFLP, CPSP and CBDMP has resulted in deep cuts to local staffing, public health prevention activities, and the numbers of clients served. At the local level, the loss of SGF has reduced or eliminated the capacity of LHJs to provide public health nurse home visiting programs, as well as the LHJs' ability to provide outreach to the community by educating the MCAH population regarding such issues as SIDS, domestic violence, injury prevention, safety promotion measures and accident prevention, preconception care, early prenatal care, STDs and family planning, access to care, oral health, breastfeeding, childhood nutrition, childhood obesity, and guidance and support.

Statewide, the LHJs allocate approximately 3.25% of Public Health Realignment funds to local MCAH programs. In FY 2006-07, total Public Health Realignment funds transferred to counties equaled $1,538,651,128. In FY 2008-09, total Public Health Realignment funds transferred to counties equaled $1,372,049,262 and FY 2009-10 will be further reduced to approximately $1,310,000,000.

Given that the current fiscal year's public health realignment funding distributions are projected to be approximately $62 million lower than FY 2008-09 distributions, the MCAH reductions in FY 2009-10 can be estimated to be approximately $2,015,000 in realignment funding and an additional $705,000 in matching Title XIX across local MCAH, BIH and AFLP programs.

>State MCAH Support
MCAH has lost the ability to leverage SGF to draw down Title XIX matching funds. The loss of $3.5 million resulted in an additional loss of approximately $1 million in federal Title XIX matching

funds. It reduced capacity at the local level to collect data has impacted the State's ability to document positive program outcomes and identify and address needed changes. State staffing levels were reduced -- vacant positions have not been filled, creating added work burden for remaining State staff. Resources were reduced to coordinate services across LHJs and advocate for vulnerable at-risk MCAH populations. There was an overall reduction in statewide meetings, which are essential to assuring statewide program equality, information sharing, training, and problem solving. There was travel reduction for state staff to audit and monitor budgets and operations and provide crucial technical assistance.

>CBDMP and CPSP
Of the $3.5 million SGF budgeted for State Operations, $1.6 million was for CBDMP. Reduced funding has caused the program to be drastically restructured.

Budget cuts to CPSP has resulted in decreased outreach to promote access to early prenatal care, decreased recruitment and training of new CPSP providers or provision of technical assistance to existing and new CPSP providers. Also, there is reduced monitoring and evaluation of CPSP providers.

>LOCAL MCAH PROGRAMS
The elimination of $2.1 million in SGF from local MCAH programs resulted in a loss of $2.1 million in Title XIX federal matching funds. Total local MCAH funds lost as a direct result of the elimination of SGF and the related Title XIX federal match was $4.2 million statewide in FY 2009-10. For every $1 of SGF cut, LHJs have experienced an additional $1 in Title XIX matched funding.

Statewide, in addition to the loss of SGF and the related Title XIX match, local funds budgeted were reduced by $1.9 million in FY 2009-10. Title XIX match to local funds will be affected by the reduction in local funds, and is estimated to be a reduction of approximately $600,000, based on projected invoices.

>AFLP
In 2009-2010, $10.7 million SGF and $5.1 million related Title XIX were eliminated for AFLP. In the 2009-2010 fiscal year, AFLP reductions resulted in 12,027 fewer clients served -- a 70% reduction in clients served. AFLP agencies experienced staff reductions of 170 full-time equivalent (FTE) statewide.

Three AFLP programs -- Riverside, San Bernardino, and Siskiyou Counties -- have been discontinued in FY 2009-10 as a result of their inability to continue activities at the current funding levels.

>Black Infant Health Program (BIH)
The 2009-2010 California budget eliminated $3.9 million SGF and $3.7 million related Title XIX to BIH programs statewide. Budget reductions have caused two sites, Riverside and San Bernardino Counties, to close.

>CMS
CMS has lost 30 positions since the 2007 reorganization of DHS into CDPH and DHCS, which together with operating expense reductions, have resulted in unmet workload and backlogs in all CMS programs including CCS. Backlogs for some CCS eligibility determinations and service authorizations in CMS Branch Regional Offices that support dependent county CCS programs now exceed three months.

As county revenues from sales, vehicle licenses, and property taxes have declined, counties have been unable to support baseline levels of services in their public health, public assistance, and safety net health care programs. The State's actions to contain expenditures, including

capping allocations of local assistance funds for CCS county administration and the CCS MTP, have exacerbated these challenges. County CCS programs maintain that the reimbursement they receive under these funding caps is inadequate for case management and care coordination, and they are cutting staff by attrition and layoffs. Some providers report that eligibility determination and authorization delays, along with the unavailability of CCS staff to assist them with claiming and reimbursement problems, may force them to stop participating in the CCS program. As with many other essential safety net programs, CCS is having difficulty meeting the needs of the CSHCN population. DHCS is working with CCS stakeholders to redesign the CCS program to more efficiently and effectively provide services to CSHCNs while maintaining access, quality of care, and optimal outcomes.

>BUDGET OUTLOOK
All signs point to another tough budget year for California for 2010-2011. The governor had included $6.9 billion in federal dollars in his January budget plan, but so far the state has received just under $3 billion. The state was hoping for unexpected gains in state revenues to significantly cut the budget deficit. However, revenues from personal and corporate taxes fell $3.6 billion short of what was projected for April 2010 the month when the bulk of revenues are collected. A significant carryover of losses from 2008 to 2009 that brought down revenues from capital gains and weakness in small business income partly explains the shortfall. That means the state's budget deficit, which at the start of 2010 was projected at $20 billion and dipped to about $18.6 billion after some midyear actions by the Legislature, could exceed the original estimate. And state legislators have stated that they do not intend to seek higher taxes this year to bridge the gap. This leaves lawmakers and the governor to face decisions such as the wholesale elimination of certain programs. More than ever, California faces the specter of this being the most damaging year for the health of children, the poor and the disabled

Recent budget actions and proposals have targeted cutting MediCal services, HF and safety-net programs for low-income women, children and those with disabilities. CalWORKS, the state's version of TANF, provides cash assistance for low-income families with children, while helping parents find jobs and overcome barriers to employment. CalWORKs is primarily a children's program: Kids make up more than three out of four recipients (77.9 percent), equivalent to 1.1 million of the more than 1.4 million Californians who are projected to receive CalWORKs cash assistance in 2010-11. Women comprise more than three-quarters (77.7 percent) of all adult recipients, and women make up an even larger share (92.5 percent) of single parents who receive cash assistance. The SSI/SSP Program provides cash assistance to help low-income seniors and people with disabilities meet basic living expenses. More than half (57.3 percent) of SSI/SSP recipients are women, equivalent to approximately 666,500 of the 1.2 million adults who are projected to receive SSI/SSP grants in 2010-11. The In-Home Support Services (IHSS) Program helps low-income seniors and people with disabilities live safely in their own homes, thereby preventing more costly out-of-home care. More than three out of five IHSS recipients (63.1 percent) are women and girls, equivalent to approximately 300,500 who are projected to enroll in IHSS in 2010-11. Women also make up the majority of caregivers that receive IHSSS employment. IHSS provides a range of services, including assistance with dressing, bathing, and medications in addition to domestic tasks such as cleaning, shopping, and meal preparation. Women comprise more than three out of five adults enrolled in the major safety-net programs that provide these benefits and services.

Medi-Cal, the state's version of Medicaid, provides comprehensive health coverage to 7.2 million Californians, including reproductive and prenatal care, and is a key component of California's safety net for low-income families. Women comprise nearly two-thirds of adult enrollees in the program. In addition, more than half of women enrolled in the program are in their peak reproductive years, a period where women seek more health services than men. Medi-Cal is also an important source of affordable coverage for unmarried women and their children. Nine out of 10 single parents enrolled in Medi-Cal are women Because women make up a large share of adult Medi-Cal enrollees, women and their children are disproportionately affected by reductions to the program.. State lawmakers made significant cuts to MediCal, CalWORKs, SSI/SSP, and

IHSS in 2009. Governor Schwarzenegger's Proposed 2010-11 Budget in January 2010 includes even deeper reductions to these programs to help close the budget gap identified by the Governor in January.

Nearly one million children and teens in California depend on HF, the state's version of SCHIP, a federal-state partnership for working poor families. HF was launched in 1998 for parents who earn too much to receive Medi-Cal coverage but who are priced out of the private insurance industry. One way for California to keep programs alive, including HF is getting the $6.9 billion in federal funds. Since California has not received the anticipated federal dollars, the threat to eliminate HF based on the May revise budget proposal is becoming more imminent.
These health and safety net programs are not administered by Title V although Title V funding is used to support the maternal and child health needs of populations that utilize these programs. The wholesale elimination of certain programs for children, the poor and the disabled will further exacerbate and create additional challenges for existing Title V administered programs to meet the needs of the vulnerable population it serves.=

A full-unabridged discussion of the budget impact to California's mothers, infants, children and CSCHN is attached.

An attachment is included in this section.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section “New State Performance Measure Detail Sheets and Data.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.